Supreme Court, U.S.
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No. _____

In The

Supreme Court of the United States

October Term, 1997

PAMELA HERTEL MERS,

Petitioner,

v.

MARRIOTT INTERNATIONAL GROUP ACCIDENTAL DEATH AND DISMEMBERMENT PLAN,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

I. Whether ERISA allows a plan insurer to deny accidental death benefits based upon a coverage definition set forth only in the group policy insuring the plan but about which the summary plan description is silent, where the definition omitted from the summary purports to exclude coverage for deaths which, although accidental, have other contributing factors such as the participant's pre-existing imperfect health.

II. Whether, under this Court's decision in *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101 (1989), the insurer of an employee welfare benefit plan which administers and interprets the plan and pays plan benefits from its own assets, has an inherent conflict of interest which should be considered a factor in determining the level of deference afforded to the plan's benefit decision by the reviewing court.

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PETITION FOR WRIT OF CERTIORARI

Petitioner Pamela Hertel Mers respectfully prays this Court for a writ of certiorari to be issued to the United States Court of Appeals for the Seventh Circuit.

OPINIONS BELOW

The final opinion of the United States Court of Appeals for the Seventh Circuit that gives rise to this petition is reported at 1998 WL 228144, and is reprinted in the Appendix hereto. App. 1. That opinion was preceded by an earlier opinion, which the Seventh Circuit vacated *sua sponte*. The vacated opinion is reported at 137 F.3d 510, and is reprinted in the Appendix hereto. App. 22. The opinion of the district court is reported at 949 F. Supp. 1323, and is reprinted in the Appendix hereto. App. 38.

JURISDICTION

The United States Court of Appeals for the Seventh Circuit entered its decision after rehearing on May 8, 1998. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTES INVOLVED

Relevant provisions of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001-1461, are set forth in the Appendix hereto. 29

U.S.C. § 1022,[1] App. 61; 29 U.S.C. § 1104, App. 63; 29 U.S.C. § 1132, App. 67.

Relevant provisions of the Code of Federal Regulations are also set forth in the Appendix hereto. 29 C.F.R. § 2520.102-2, App. 77; 29 C.F.R. § 2520.102-3, App. 81.

STATEMENT OF THE CASE

1. Statement of Facts.

This case was filed by Petitioner Pamela Hertel Mers, the widow of Dale Mers, against the Marriott International Group Accidental Death and Dismemberment Plan ("Plan"). Dale Mers was employed by Marriott International, Inc. ("Marriott"), which provided its employees with accidental death and dismemberment ("A D & D") benefits. The Plan was insured under two group policies issued by American International Group through one of its subsidiaries.[2] AIG administered claims under the Plan and, as the insurer, paid benefits out of its own assets. The Plan included two types of A D & D benefits, Business Travel Accidental ("BTA") and 24-Hour Optional ("24-Hour"). As an employee of Marriott, Dale Mers received $100,000 in BTA coverage automatically. He paid additional premiums to receive $100,000 in 24-Hour coverage.

Petitioner Pamela Hertel Mers seeks recovery of $200,000 in A D & D benefits predicated upon Dale Mers' accidental death. Dale Mers was a 44-year old father of

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[1] 29 U.S.C. § 1022 was amended in 1996. That amendment has no impact on the issues presented in this Petition.

[2] American International Group and its subsidiaries will be jointly referred to herein as "AIG."

two at the time of his death and was a Director of National Sales for Marriott. App. 2. As part of a work-related conference, Dale was using a sledge hammer and crowbar to tear down a wall while working with Habitat for Humanity in the rehabilitation of a home when, without warning, he suffered a cerebral hemorrhage and died. *Id.* Although Dale's usual work at Marriott was sedentary, his work at the Habitat for Humanity house required an unusual amount of physical exertion. *Id.* Other than being overweight, and having non-insulin-dependent diabetes, Dale was in good physical health and had no prior history of hypertension, vascular, or coronary problems. *Id.* Doctors who opined as to the cause of Dale Mers' death concluded that his death resulted from a combination of his unusual physical exertion at the project and his pre-existing imperfect state of health. *Id.* at 5.[3]

The summary plan description ("SPD") given to Plan participants stated, with respect to BTA coverage, that benefits were payable if the participant should die "in an accident" while traveling on Marriott business. App. 3. The SPD stated that 24-Hour benefits were payable if the insured "suffers an accidental loss of life." *Id.* No definition of "accident" or "accidental" was set forth anywhere in the SPD. The district court found that Dale Mers suffered an accidental loss of life while traveling on Marriott business, a finding which was accepted by the Seventh Circuit. *Id.* at 54-55.

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[3] A more detailed recitation of the facts surrounding both Dale Mers' death and the administrative review of Petitioner's claim for A D & D benefits is set forth in the Seventh Circuit's May 8, 1998 decision. App. 1-7.

The Plan, however, denied payment of the A D & D benefits based upon the term "injury" and its definition found in the insuring group policies. *Id.* at 12. As set forth in the policies, "injury" was defined as "bodily injury caused by an accident and resulting directly and independently of all other causes in loss covered by the policy." *Id.* at 20. That term, and its definition, were omitted from the SPD given to plan participants.[4] The Plan interpreted the term injury and its definition as limiting accidental death coverage to deaths which, although accidental, were not contributed to, in any measure, by anything else other than the accident, including the insured's pre-existing imperfect health. *Id.* at 20-21.

In denying Petitioner's claim for benefits, the Plan also cited an exclusion for deaths caused by or resulting from disease. Neither the SPD nor the insuring policies defined "disease" or explained the extent to which a disease had to contribute to the accidental death in order to render the death excluded from coverage. The disease from which the Plan contended that Dale Mers suffered was a "weakened blood vessel."

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[4] Although both the Seventh Circuit and the district court opinions state that the SPD relating to the 24-Hour coverage does contain the definition of the term "injury," those statements are unsupported by the record. The only mention of the term "injury," or its definition, outside of the group insuring policies, is its appearance, in small print, in a definitional section of the certificate of insurance relating to the 24-Hour coverage. There is no mention of the term or its definition in the SPD. Mers' Supplemental Appendix to Seventh Circuit, pp. 15-42.

2. District Court Proceedings.

Petitioner filed her ERISA complaint in 1995, invoking the district court's jurisdiction under 29 U.S.C. § 1132. After written discovery was completed, the Plan filed a motion for summary judgment. Shortly thereafter, Petitioner filed a cross-motion for summary judgment. The district court granted the Plan's motion and denied Petitioner's motion.

The district court agreed with Petitioner that a judicial review of the Plan's denial decision required less deference because the Plan insurer, acting as Plan administrator, was operating under a conflict of interest when it denied Petitioner's claim. App. 49. The district court also concluded that Dale Mers' death was accidental. *Id.* at 55.

The district court, however, upheld the Plan's decision to deny benefits for Dale Mers' accidental death, holding that the Plan's reliance on the "injury" definition to limit coverage was not precluded, and that the insurer's interpretation of that definition was reasonable. App. 59. The district court rejected Petitioner's argument that the omission of the term and its definition from the SPD violated ERISA, 29 U.S.C. § 1022, and estopped the Plan from relying on the definition to deny coverage. *Id.* at 51 n.5.

In addition, the district court placed the burden upon Petitioner to prove that the policy exclusion for disease did *not* apply to exclude coverage. *Id.* at 51. The court stated that Petitioner had failed to show that the death was not caused by disease. *Id.* at 59.

3. Seventh Circuit Proceedings.

a. First Opinion.

On January 3, 1997, Petitioner appealed the district court's ruling. On February 24, 1998, the Seventh Circuit affirmed the district court's decision, ruling that although the SPD does not explain whether the Plan provides benefits where there is more than one cause for an accidental death, the definition of injury found in the group policies, and used to deny coverage, clarifies the ambiguity caused by the omission of the definition from the SPD. App. 35. The court held that because the injury definition "clarifies and does not contradict the terms of the SPD, the Plan is not estopped from relying on it." *Id.* at 36. Further, the court rejected Petitioner's argument that there *was* a contradiction between the SPD and the policies, as "simply a reformulation of the argument that beneficiaries should be able to use only the SPD and never consider whether additional terms exist." *Id.* The court did not reach the issue of whether Dale Mers' death fell within the disease exclusion. *Id.* at 32-33 n.2.

In addition, the Seventh Circuit ruled that the district court erred in holding that there was an inherent conflict of interest because a plan insurer, paying claims out of its own assets, made the decision to grant or deny claims. *Id.* at 30. The court held that in that situation, in order to have a Plan's decision reviewed with less deference, the burden is on the participant or beneficiary to come forward with evidence of "actual and significant bias." *Id.* at 31.

b. Petition for Rehearing.

On March 10, 1998, Petitioner filed a Motion to Stay the Issuance of the Mandate for purposes of petitioning this Court for a writ of certiorari. That motion was granted on March 13, 1998. On March 20, 1998, after discovering the then-recent Seventh Circuit decision in *Williams v. Midwest Operating Eng'rs Fund*, 125 F.3d 1138 (7th Cir. 1997), which was in direct conflict with the Seventh Circuit's ruling in this case, Petitioner filed a Motion for Leave to File a Petition for Rehearing With Suggestion for Rehearing En Banc. That motion was granted, and the parties submitted their briefs on rehearing.

On April 15, 1998, the Seventh Circuit entered an order vacating its February 24, 1998 decision *sua sponte*. A new decision was then circulated to the entire court pursuant to Rule 40(e) of the Rules of the United States Court of Appeals for the Seventh Circuit. The majority of active judges did not favor a rehearing en banc, although Judges Cummings and Rovner voted to grant such a rehearing. *Id.* at 1.

On May 8, 1998, the Seventh Circuit issued its second decision.[5] In that decision, the court acknowledged the conflict that its decision in the present case created with its prior decision in *Williams*, and then overruled its decision in *Williams*.[6] In *Williams*, the court had ruled that

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[5] With respect to the court's analysis of the conflict of interest issue, the decision remained unchanged. *Compare* App. 9-12 with App. 30-33.

[6] The decision in *Williams* was handed down five months prior to the Seventh Circuit's first opinion in the present case.

because the SPD omitted a definition of "injury" found only in the plan documents, the plan could not rely upon that definition to limit benefits. *Id.* at 14. The court also held that the undefined term "injury" in the SPD was to be given its common meaning. *Id.* at 15. In overruling that decision in the present case, the court stated that it had erred in *Williams* in estopping the plan from relying on the omitted definition. Specifically, the court held that there was no direct conflict between the SPD and the plan documents but only a discrepancy caused by the fact that the SPD omitted the plan's definition of "injury" and then defined it in an underlying plan document in a way which differed from the term's common meaning. *Id.* at 16.

In the present case, the Seventh Circuit held that silence in an SPD can never be allowed to trump provisions in the underlying plan. *Id.* at 15-19. The court ruled that the Plan was not estopped from relying on the limiting definition because, although the SPD was silent on the limitation, there was no direct contradiction between the two documents. *Id.* The court reasoned that "[c]larity and completeness are competing goods" and "[w]e have accounted for these dueling considerations by allowing claimants to rely on an SPD when the policy terms contradict." *Id.*

REASONS FOR GRANTING THE WRIT

This Court should grant this Petition for Writ of Certiorari because the decision below is in direct conflict with the decisions of several other Circuit Courts of Appeal; because this Court has never before ruled upon

the issues presented and there is a great need for the guidance of this Court based upon the lack of uniformity in the statutory construction and administration of ERISA by the lower courts; and because the issues presented by this Petition will have an important impact on the ability of all participants and beneficiaries of employee benefit plans to understand and secure their benefits in the future.

I. The Opinion of the Seventh Circuit Directly Conflicts With Decisions of the Third, Sixth, Eighth, Tenth, and Eleventh Circuits With Respect to Whether Section 1022 of ERISA Precludes a Plan From Denying Benefits Based Upon a Limitation Omitted from a Summary Plan Description.

There is a clear circuit split on the important issues of what Section 1022 of ERISA, 29 U.S.C. § 1022, requires to be included in a summary plan description ("SPD"), and the consequences of a plan's failure to include this required information. This Court has never before considered either of these issues.

SPD's are central to ERISA's purpose of protecting the interests of employees and their beneficiaries by providing accurate and complete information relating to promised benefits. H.R. No. 93-533, 93rd Cong. 2d Sess., *reprinted in* 1974 U.S.C.C.A.N. 4639, 4646. A review of the diverse holdings of the different Circuit Courts of Appeal, and indeed conflicts among different panels of the same circuits, makes clear the dire need for this

Court's guidance in this key area of ERISA interpretation.[7]

The Third, Sixth, Eighth, Tenth, and Eleventh Circuit Courts of Appeal have held that where a term is omitted from an SPD, but included in other plan documents, the plan may not rely upon the omitted term to deny benefits to a participant or beneficiary. *Genter v. Acme Scale & Supply Co.*, 776 F.2d 1180, 1186 (3rd Cir. 1985) (omission from an SPD of information advising a participant that he could have increased his life insurance benefits "midstream" violated Section 1022 and the plan could not deny payment of the increase amount to the beneficiary); *Edwards v. State Farm Mutual Ins. Co.*, 851 F.2d 134, 136 (6th Cir. 1988) (plan's decision to deny benefits was arbitrary and capricious where plan relied upon a definition of "date of disablement" omitted from the SPD); *Dodson v. Woodmen of the World Life Ins. Soc'y*, 109 F.3d 436, 439 (8th Cir. 1997) (an omission from the SPD of a time limit violated Section 1022 and barred plan from denying benefits based upon that limit); *Bartlett v. Martin Marietta Operations Support, Inc. Life Ins. Plan*, 38 F.3d 514, 518 (10th Cir. 1994) (omission of definition of "actively at work" from benefits workbook precluded the plan from denying benefits based upon the definition found only in the plan); *Brown v. Blue Cross and Blue Shield of Alabama, Inc.*, 898 F.2d 1556, 1570 n.16 (11th Cir. 1990) (fact that SPD omitted phrase allowing plan discretion as to what constitutes an emergency, precluded plan from relying on the omitted phrase to deny benefits).

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[7] This confusion is confirmed by the fact that the Seventh Circuit handed down completely conflicting holdings on this issue within a five-month period.

While the Seventh Circuit's decision in *Williams* was consistent with this line of cases, it used the present case to overrule *Williams*. The Seventh Circuit ruled in this case that Section 1022's requirement that the SPD "shall" present a description of all circumstances which may result in a denial of benefits is not violated where an SPD is silent as to a limitation of benefits if the limitation is set forth in the insuring group policy. In support of its holding, the court cited decisions from the Fourth, Fifth, Sixth, and Eighth Circuits. *Wise v. El Paso Nat. Gas. Co.*, 986 F.2d 929, 938 (5th Cir. 1993) (clear and unambiguous statements in an SPD are binding but the same is not true of silence); *Martin v. Blue Cross & Blue Shield of Va., Inc.*, 115 F.3d 1201, 1204 (4th Cir. 1997), *cert. denied*, 118 S. Ct. 629 (1997) (silence in the SPD on discretion issue is not a conflict which would estop plan from exercising discretion); *Sprague v. General Motors Corp.*, 133 F.3d 388, 401 (6th Cir. 1998) (*en banc*), *cert. denied*, 118 S. Ct. 2312 (1998) (employer's failure to include in SPD notice of a right to change its plan does not control over clearly-stated right to do so stated in underlying plan documents)[8]; *Jensen v. SIPCO, Inc.*, 38 F.3d 945, 952 (8th Cir. 1994) (rule that SPD controls where there is a conflict "does not apply when the plan document is specific and the SPD is silent on a particular matter").

In fact, this issue has resulted in inconsistent holdings from different panels in several of the circuits. For example, two panels of the Eighth Circuit have held that

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[8] *Sprague*'s holding respecting the binding effect of SPDs involved the claims of nearly 85,000 retirees. This fact highlights the recurring and widespread importance of the issues presented in this Petition.

where an SPD is silent on a limitation or requirement found elsewhere in the plan documents, the plan cannot enforce the limitation or requirement. *Dodson*, 109 F.3d at 439; *Lutheran Med. Ctr. of Omaha, Neb. v. Contractors, Laborers, Teamsters and Engineers Health and Welfare Plan*, 25 F.3d 616, 621-623 (8th Cir. 1994) (silence in SPD on definition of coverage and on limitation of benefit amount precludes plan from relying on definition or limitation to deny benefits). In *Jensen*, on the other hand, another panel of the Eighth Circuit held that the rule that SPD's control over inconsistent plan provisions does not apply where the SPD is silent. *Jensen*, 38 F.3d at 952.

In the Sixth Circuit's seminal case on this issue, *Edwards*, 851 F.2d at 135-36, the SPD failed to define what the plan meant by "date of disablement," and the Sixth Circuit precluded the plan from applying a definition found elsewhere in the plan to deny coverage, holding that allowing the plan to do so would circumvent the purpose of Section 1022. In *Sprague*, conversely, the majority of the Sixth Circuit, en banc, held that silence in an SPD does not control over clearly stated rights set forth in other plan documents relating to the vesting of welfare benefits. The court in *Sprague* specifically held that the principle announced in *Edwards* "does not apply to silence." *Id.* at 401.[9]

At present, the case law with respect to what must be included in an SPD is so confused that neither benefit

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[9] Three judges dissented from the *Sprague* holding, finding that the principle announced in *Edwards* required the SPD to control. *Sprague*, 133 F.3d at 411.

plans nor participants can accurately predict how a federal court will interpret the requirements of ERISA's Section 1022. There is a clear need for this Court to issue a uniform interpretation of these important and recurring questions of statutory interpretation and administration.

A. The Seventh Circuit's Opinion on this Significant Issue of ERISA Administration Is Inconsistent with the Intent and Purpose of the Statute as Well as its Express Mandate.

The Seventh Circuit's decision in the present case is completely at odds not only with ERISA's purpose and intent but its clear mandate. "ERISA is a comprehensive statute designed to protect the interests of employees and their beneficiaries in pension and welfare benefit plans." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989). ERISA protects plan participants and beneficiaries, in part, by requiring that the plan administrator provide each participant with an SPD. 29 U.S.C. § 1022. The SPD is required to present information about the plan in "a manner calculated to be understood by the average plan participant." 29 C.F.R. § 2520-102-2. ERISA mandates that the SPD "shall" contain, among other information, "circumstances which may result in disqualification, ineligibility, or denial or loss of benefits . . . " 29 U.S.C. § 1022(b). Federal regulations also require that an SPD "must not have the effect of misleading, misinforming, or *failing to inform* participants and beneficiaries." 29 C.F.R. § 2520.102-2(b) (emphasis added).[10]

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[10] The United States Department of Labor, which is charged with drafting rules and regulations relating to ERISA's

In order to secure compliance with ERISA's statutory mandate, courts have ruled that an SPD controls over inconsistent provisions in the underlying plan documents. That rule is required because, without it, the purpose of an SPD – to present employees with accurate, understandable, and easily accessible information about their benefits – would be eviscerated. The result of allowing information not disclosed to plan participants in the SPD to control:

> would be that before a participant in the plan could make any use of the summary, she would have to compare the summary to the policy to make sure the summary was unambiguous, accurate and not in conflict with the policy. Of course, if a participant has to read and understand the policy in order to make use of the summary, then the summary is of no use at all.

Hansen v. Continental Ins. Co., 940 F.2d 971, 981-82 (5th Cir. 1991).

The average participant or beneficiary of an ERISA plan relies upon the accuracy and completeness of the summary to make important choices, for example, whether and where to secure medical care or whether he or she needs to buy additional insurance. *Helwig v. Kelsey-Hayes Co.*, 93 F.3d 243, 250 (6th Cir. 1996), *cert. denied*, 117

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disclosure requirements, submitted an amicus curie brief to the Sixth Circuit in *Sprague*, stating the Department's position that benefits promised in an SPD must always control over inconsistent plan provisions, whether the inconsistency arises out of an affirmative contradiction *or out of a failure to include information*. Petitioner respectfully suggests that the Court would be assisted by requesting the views of the Department of Labor on the issues set forth in this Petition.

S. Ct. 690 (1997). Even in the rare case where the underlying policy documents are given, or made available, to participants (and assuming that the participant can read English) the technical language employed in group insurance contracts is well beyond the comprehension of most plan participants.[11]

As the Eleventh Circuit stated in *McKnight v. Southern Life & Health Ins. Co.*, 758 F.2d 1566, 1570 (11th Cir. 1985):

> It is of no effect to publish and distribute a plan summary booklet designed to simplify and explain a voluminous and complex document and then proclaim that any inconsistencies will be governed by the plan. Unfairness will flow to the employee for reasonably relying on the summary booklet.

The Seventh Circuit's opinion in this case is inconsistent with the purpose and intent behind ERISA's SPD requirement. A rule of law that an SPD may be silent on circumstances which may result in the denial of benefits will require all plan participants and beneficiaries to secure all underlying plan documents, and read and understand their highly technical language, in order to have any realistic understanding of the extent of the benefits provided. This fact, of course, defeats the basic purpose of providing the summary.

Even if the participant takes the extreme measure of reading all plan documents, he may not be adequately protected or have an accurate picture of his benefits. In

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[11] Federal regulations require that employers with employees who speak other languages make provision for that fact in the SPD. 29 C.F.R. § 2510.102-2(c). There is no similar regulation relating to underlying plan documents.

some circuits, the doctrine of contra proferentem, which generally allows courts to read ambiguities in insurance policies against the insurance company, is not applied to ERISA-governed insurance contracts. *See, e.g., Morton v. Smith*, 91 F.3d 867, 871 n.1 (7th Cir. 1996). Accordingly, even if a participant believes he is entitled to benefits based upon the common meaning of terms used in the group insurance contract, the insurer is free to interpret ambiguous terms in its own policy differently to deny benefits. Moreover, even if the diligent participant went so far as to ask the plan to confirm the nature and extent of the plan benefits being offered, the plan's assurances would be unenforceable in most circuits because the doctrine of promissory estoppel is unavailable under ERISA. *See, e.g., Alday v. Container Corp. of America*, 906 F.2d 660, 662 (11th Cir. 1990).

In sum, the Seventh Circuit's opinion not only fails to protect plan participants and beneficiaries but leaves them much worse off than prior to the enactment of ERISA, a result which is completely contrary to the Act's purpose of protecting beneficiaries. *See Firestone*, 489 U.S. at 113.

B. The Seventh Circuit Ignores ERISA's Mandate in Order to Fashion Its Own Judicially-Crafted Balancing Test.

ERISA expressly requires that every SPD "shall" set forth all circumstances that might lead to a denial of benefits. 29 U.S.C. § 1022(b). Despite the mandatory language of the statute, the Seventh Circuit in the present case has created its own balancing test to determine when a plan will be estopped from denying benefits based

upon an SPD which omits circumstances which might lead to a denial of benefits. The court stated that it created its test in order to balance what it declares are the competing goods of "clarity and completeness." App. 19. The court held that a promise of benefits reflected in an SPD will only estop a plan from relying on inconsistent plan documents where the SPD and the underlying documents *directly contradict*. *Id.* at 18. Inasmuch as silence in an SPD will never directly contradict anything, the court reasoned that silence can never be held to control over plan terms found in the underlying plan documents. *Id.*

There are several problems with the Seventh Circuit's test. *First*, it contradicts ERISA's express requirement that every SPD be both accurate and comprehensive, as well as federal regulations requiring an SPD to "not have the effect of misleading, misinforming or failing to inform participants and beneficiaries of a plan." 29 U.S.C. § 1022; 29 C.F.R. § 2520-102-2; 29 C.F.R. § 2520-102-3. *Second*, the test will undermine ERISA's central role – furthered so importantly by the SPD – as a protector of plan participants and beneficiaries. If plans are allowed to omit from SPDs information which substantially narrows benefits (or are allowed to use ambiguous terms, then define those terms to alter their common meaning in other plan documents) participants will never be secure in their understanding of their rights under a plan and indeed, plans may well have an incentive to omit relevant information from SPDs. *Third*, the test fails to accomplish what it supposedly sets out to do because allowing plans to be silent on relevant information in the SPD fails to secure either clarity or completeness in the plan description.

In addition, the Seventh Circuit, in attempting to account for what it sees as the "dueling considerations"

of clarity and completeness, has created a test which is itself unclear. The court held that there must be a "direct contradiction" between an SPD and a plan document to estop a plan from denying benefits based upon the plan document and the court then reasoned that silence cannot directly contradict anything. If a major limitation of coverage is not included in an SPD's description of benefits but is included in an underlying plan document, application of that limitation *will* directly contradict the participant's reasonable understanding of his right to benefits. The fact that silence as to a limitation on coverage can directly contradict an underlying plan document containing a benefit limitation is clear from the present case. Here, the SPD promised Dale Mers accidental death benefits. The insuring policy denied those benefits despite Dale's death from accident. Benefits were promised under the language of the SPD – none were payable under the language of the insuring policy. Thus, there *was* a direct contradiction between the documents.

In its original opinion, the Seventh Circuit rejected Petitioner's argument that the SPD and the policy were in direct conflict as "simply a reformulation of the argument that beneficiaries should be able to use only the SPD and never consider whether additional terms exist." *Id.* at 36. The court's response to Petitioner's argument encapsulates the problem with its reasoning in both opinions – the intent and purpose of ERISA's requirement of a summary plan description is to allow plan participants to have an accurate picture of their benefits without having to "consider whether additional terms exist."

What the Seventh Circuit has created in the present case is a test which, if allowed to stand, would negate the principal purpose of ERISA which is to "protect plan

participants and beneficiaries." *Boggs v. Boggs*, 117 S. Ct. 1754, 1762 (1997). This Court should take this opportunity to confirm the importance of strict adherence to ERISA's statutory scheme, including the requirement that participants be provided an accurate description of plan benefits through the dissemination of summary plan descriptions.

II. The Opinion of the Seventh Circuit Directly Conflicts With Decisions of the Fourth, Tenth, and Eleventh Circuits on The Important Issue of the Appropriate Standard of Judicial Review to Apply in Cases Involving Benefit Denials by Plan Insurers Administering Their Own Insurance Policies.

This Court has held that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'factor in determining whether there is an abuse of discretion.' " *Firestone*, 489 U.S. at 115, *quoting* Restatement (Second) of Trusts § 187, Comment *d* (1959). The Circuit Courts of Appeal, however, are now split as to how to interpret this Court's admonition, especially where, as here, the plan is insured and the plan insurer administers benefits funded by its own assets.

The Seventh Circuit in the present case held that no presumptive conflict of interest exists where an insurance company serves as a plan fiduciary which administers benefits paid with its own assets. In so ruling, the court recognized that its position conflicted with the holdings of other Circuit Courts of Appeal. App. 10 ("While some

courts have found that a denial of benefits is presumptively void and must be reviewed de novo where a similar conflict may exist, see Brown, 898 F.2d at 1561, we have not.").[12] In fact, the Seventh Circuit's decision on this issue is in direct conflict with at least three Circuit Courts of Appeal which have held that such an arrangement creates an inherent conflict of interest mandating a heightened standard of judicial review of the benefit decisions made by the insurer. *Brown v. Blue Cross & Blue Shield of Alabama*, 898 F.2d 1556, 1561 (11th Cir. 1990); *Doe v. Group Hospitalization & Medical Serv.*, 3 F.3d 80, 86 (4th Cir. 1993); *Pitman v. Blue Cross and Blue Shield of Oklahoma*, 24 F.3d 118, 123 (10th Cir. 1994).

The decisions of the Fourth, Tenth, and Eleventh Circuits are the better reasoned decisions. ERISA requires plan fiduciaries to discharge their duties with respect to the plan solely in the interest of the participants and beneficiaries, and for the exclusive purpose of "providing benefits to plan participants and their beneficiaries." 29 U.S.C. § 1104. This Court in *Firestone*, held that "[i]n determining the appropriate standard of review for actions under § 1132(a)(1)(B), we are guided by the principles of trust law." *Firestone*, 489 U.S. at 111. "One of the

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[12] The Seventh Circuit was incorrect when it stated that *Brown* held that a de novo review was required of a decision made by a fiduciary operating under an inherent conflict of interest. In fact, the court in *Brown* specifically held that a "court should *not* exercise de novo review, but the area of discretion to which deference is paid must be confined narrowly to decisions for which the conflicted fiduciary can demonstrate that it is operating exclusively in the interests of the plan participants and beneficiaries." *Brown v. Blue Cross & Blue Shield of Alabama*, 898 F.2d 1556, 1568 (11th Cir. 1990) (emphasis added).

primary obligations imposed upon fiduciaries of employee benefit plans by ERISA is the avoidance of conflicts of interests." *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 141 (1985). The common law of trusts prohibits fiduciaries from holding positions that create a conflict of interest with trust beneficiaries. *NLRB v. Amax Coal Co.*, 453 U.S. 322, 329-330 (1981).

The Fourth, Tenth, and Eleventh Circuits all correctly recognize that an ERISA fiduciary has a duty of loyalty to plan beneficiaries which lies in perpetual conflict with the profit-making role of an insurance company as a business. *Brown*, 898 F.2d at 1561; *Doe*, 3 F.3d at 86; *Pitman*, 24 F.3d at 123. This conflict between an insurance company's profit motive and its statutory fiduciary duty of loyalty is obvious. In exercising its discretion as to whether to grant or deny benefits in a particular case, the insurer "incurs direct, immediate expense as a result of benefit determinations favorable to plan participants." *Brown*, 898 F.2d at 1561. As stated by the court in *Doe* "to the extent that [the insurer] has discretion to avoid paying claims, it thereby promotes the potential for its own profit," and:

> [e]ven the most careful and sensitive fiduciary in those circumstances may unconsciously favor its profit interest over the interests of the plan, leaving beneficiaries less protected than when the trustee acts without self-interest and solely for the benefit of the plan.

Doe, 3 F.3d at 86-87.

Under traditional trust law principles, in order to limit the deference usually bestowed upon an impartial fiduciary, a beneficiary needs only to demonstrate that a

fiduciary has placed itself in a position where its own interests *might* conflict with the interests of the beneficiaries. *Brown*, 898 F.2d at 1565. "It is unnecessary to show that the fiduciary succumbed to this temptation" in order to give rise to the legal presumption that the fiduciary has acted disloyally. *Id.* (citations omitted). As this Court has stated, "[a] fiduciary cannot contend 'that, although he had conflicting interests, he served his masters equally well or that his primary loyalty was not weakened by the pull of his secondary one.' " *NLRB*, 453 U.S. at 330.

In the present case, the Seventh Circuit not only rejected the holding of its sister circuits but imposed a presumption of neutrality, stating, "[w]e presume that a fiduciary is acting neutrally unless a claimant shows by providing specific evidence of actual bias that there is a significant conflict." App. 10. Although apparently accepting the conclusion that an insurer who administers its own policies has an "inherent relational conflict," the court applied what it termed a "law-and-economics" rationale "to establish that no conflict exists." *Id.* Based upon that rationale, the court refused to review the plan insurer's denial of benefits with anything but the greatest deference. App. 13 ("Our role is to determine whether the decision was completely unreasonable").

The Seventh Circuit advanced two reasons why, in its view, no conflict of interest was presented by allowing the insurer alone to make benefit decisions relating to the plan which it insured. First, the court reasoned that because the insurer, AIG, was "one of the fifty largest companies in the 'Fortune 500' listing," paying the $200,000 in benefits sought by Petitioner was too

"minuscule" compared to its bottom line to create a conflict. *Id.* at 11. Of course, this analysis ignores the economic reality that although it may have been possible that AIG's adjustor was not consciously motivated by AIG's bottom line when he denied Petitioner's claim, the fact that AIG's profit motive is directly served by denying the claim, nonetheless left Petitioner "less protected than when the trustee acts without self-interest and solely for the benefit of the plan." *Doe*, 3 F.3d at 86-87.[13]

Moreover, benefit decisions made by an insurance company are not made in a vacuum. A decision to grant or deny a particular benefit claim may well impact whether future claims filed by plan beneficiaries are granted or denied. The bottom line of any insurance company, wealthy or not, is by definition the product of the amounts it earns in premiums on the policies it issues less the amount it pays out in claims under those policies. It is this indisputable fact which creates the conflict. It is simply not realistic to believe, as the Seventh Circuit does, that an insurer's decision-making process with respect to the granting or denial of a claim made under its own policies is unaffected by its desire to become – or remain – a "Fortune 500" company.

The Seventh Circuit's second reason for determining that no conflict exists is that "in the long run" a practice by an insurer of denying claims would be a "poor business decision" because if employees are unhappy because valid benefit claims are not being paid, that unhappiness

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[13] The court's analysis may well create a double standard, with courts granting more deference to the decisions of wealthy companies than to financially troubled companies.

may cause the employer to seek insurance coverage elsewhere. App. 11. The court did not, however, discuss the equally compelling economic fact that it is a "poor business decision" for an insurer *not* to deny benefit claims. Every time an insurer makes a decision to pay a claim, that decision impacts the amount of the premium which the insurer must charge in order to maintain its profit margin. The greater the number of claims paid, the higher the premium and the less competitive the insurer's products become in the marketplace. As stated by the Eleventh Circuit in *Lee v. Blue Cross/Blue Shield of Alabama*, 10 F.3d 1547, 1551 (11th Cir. 1994), even a nonprofit insurer has a motive to deny coverage based upon business considerations:

> Even without a profit motive, Blue Cross' desire to maintain competitive rates while providing optimum benefits would require it to reject marginal claims. If Blue Cross paid every claim submitted to it, its premiums would skyrocket. The fact that it does not pay every claim indicates that some form of self-interest, whether profit or the company's continued existence and success, is at work. The standard of review must be adjusted to reflect the inherent conflict in Blue Cross administering claims under a policy it issues.

The courts have recognized that it is common for an employer to contract with an insurance company to provide and administer benefits through group insurance contracts. *Doe*, 3 F.3d at 86. The prevalence of this type of relationship in ERISA-governed plans underscores the need for uniformity in the treatment of the issue of what level of review should be afforded by a court considering

the decision of an insurer administering plan benefits under its own policy.

In addition, it is crucial to ERISA's purpose that benefit decisions be afforded the proper standard of judicial review. "ERISA is a comprehensive statute designed to protect the interests of employees and their beneficiaries in pension and welfare benefit plans." *Firestone*, 489 U.S. at 113. As this Court recognized in *Firestone*, because "the validity of a claim to benefits under an ERISA plan is likely to turn on the interpretation of the terms in the plan," application of the correct standard of review of benefit claims is critical to ensuring that ERISA's purpose is met. *Id.* at 115. ERISA's purpose would be eroded if the standard of judicial review applied by lower courts afforded "less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted." *Id.* at 114.

This Court in *Firestone* recognized that ERISA's language and history dictates the application of trust law principles to determine the appropriate standard of review for benefit actions. *Id.* at 111. Of course, trust law does not even allow a trustee to serve both its own interests and those of the trust. *NLRB*, 453 U.S. at 329-330. In fact, ERISA expressly bars fiduciaries from engaging in self-interested transactions with the plan. 29 U.S.C. § 1106. However, because ERISA's definition of "trust assets" excludes the assets of an insurance company insuring a plan, ERISA has been interpreted to allow insurers to act as plan fiduciaries administering their own policies. 29 U.S.C. § 1103(a).

The fact that ERISA does not bar all fiduciaries with conflicted interests from making benefit decisions, however, does not mean that trust principles are to be disregarded. Rather, as this Court has made clear, when a fiduciary with discretion to make plan benefit decisions operates under a conflict of interest, that conflict is a factor to be considered by the reviewing court in determining the appropriate level of deference to be afforded the plan fiduciaries' benefit decisions. *Firestone*, 489 U.S. at 115. Where the conflict of interest "flows inherently from the nature of the relationship entered into by the parties," a lower level of deference must be afforded the conflicted fiduciaries' decision. *Brown*, 898 F.2d at 1568; *Pitman*, 24 F.3d at 123; *Doe*, 3 F.3d at 86.

Giving an insurer the same high level of discretion given impartial trustees of true trusts would result in plan participants and beneficiaries having less protection than they were afforded before ERISA. Prior to the enactment of ERISA, an insurer's decisions relating to benefits funded by an insurance policy were reviewed de novo, with the court applying the rule of contra proferentem to construe ambiguous policy terms in favor of the insured. *See Phillips v. Lincoln Nat'l Life Ins. Co.*, 978 F.2d 302, 311-313 (7th Cir. 1992). ERISA, however, allows plans to grant discretion to plan fiduciaries to interpret the plan terms and determine eligibility for plan benefits. Where that discretion is granted to a fiduciary whose self-interest is served by denying claims, the only way that courts have to protect plan participants and beneficiaries from this conflict of interest is to heighten their review of the benefit decision. Without such a heightened review, insurers with discretion would be free to interpret their own policies and deny all claims for plan benefits with

the knowledge that their denials would be reversed only in those cases where a court deems the denial "completely unreasonable." App. 13. To deny meaningful review of plan decisions made by insurers administering their own policies would stand ERISA on its head.

The Seventh Circuit's decision, which refuses to acknowledge that a substantial conflict of interest exists where the insurer administers its own policies, places a new and nearly impossible burden on a plan participant or beneficiary seeking a meaningful review of the insurer's denial of benefits. The court not only refused to presume that a conflict arises where an administrating insurer pays benefits out of its own assets, it places a burden on plan participants and beneficiaries to overcome a presumption of neutrality and come forward with "specific evidence of actual bias." App. 10.[14] The court gave no example of what it meant by "specific evidence of actual bias." Its analysis makes clear, however, that it would not consider evidence that the insurer receives a direct financial benefit from a denial decision as sufficient to meet this actual and significant bias standard. In fact, it is difficult to imagine what type of evidence a plan participant or beneficiary could produce, using the court's "law and economics" approach, which would ever overcome the court's presumption of neutrality.

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[14] The Seventh Circuit relied on its own decision in *Cuddington v. Northern Ind. Pub. Serv. Co.*, 33 F.3d 813, 816 (7th Cir. 1994), in support of this statement. *Cuddington*, however, does not involve an insurer paying benefits from its own assets but rather an employer-administered trust paying benefits out of trust assets.

Not only is the Seventh Circuit's decision inconsistent with trust law principles, it effectively insulates plan insurers from liability for all but the most unquestionable claims for benefits. ERISA places a statutory duty of loyalty on a fiduciary. 29 U.S.C. § 1104(a)(1)(A). Traditional principles of trust law do not require a beneficiary to show more than a potential conflict of interest in order to raise a presumption of disloyalty. *Brown*, 898 F.2d at 1565 (citations omitted). The Seventh Circuit, in contrast, held that a "potential conflict is not enough." App. 10. The consequence of the court's holding is to make it even more difficult for plan participants and beneficiaries to secure the benefits they are due. As the Tenth Circuit noted in *Pitman*, "ERISA cannot be manipulated into a federal safe haven for [ ] insurers who fall within the ambit of employee welfare benefit plans." *Pitman*, 24 F.3d at 124 (ellipsis in original).

This Court has previously recognized that the courts must "fill the gap" within ERISA with respect to the appropriate amount of discretion to be afforded by the federal courts to a fiduciary's decision denying plan benefits. *Firestone*, 489 U.S. at 109. Yet despite this Court's dictate that there be a "federal common law of rights and obligations under ERISA-regulated plans," as it now stands there is a direct conflict between the Seventh Circuit and the Fourth, Tenth, and Eleventh Circuits as to whether benefit decisions made by insurers administrating their own group policies should be subjected to heightened judicial review. This Court should seize this opportunity to cure this conflict, and again confirm that a conflict of interest "must be weighed as a factor in determining whether there is an abuse of discretion." *Id.* at 115.

CONCLUSION

This Court should grant this Petition for Writ of Certiorari because the decision of the Seventh Circuit in this case conflicts with several other Circuit Courts of Appeals on both of the issues presented and because the resolution of these issues will have an important and continuing impact on the ability of all participants and beneficiaries of employee benefit plans to understand and secure their benefits in the future.

This Court has never before addressed what information is required by Section 1022 to be included in an SPD nor has it stated the consequences of a plan's failure to include the required information. The Seventh Circuit's decision in this case exacerbates the wide and pervasive split in the holdings of various Circuit Courts of Appeal with respect to this important issue. Without this Court's direction, the lower courts, as well as plan participants and beneficiaries, will continue to be confounded by the lack of uniformity on this important issue of federal law.

With respect to the second issue presented, the decision in this case creates a direct conflict between the Seventh Circuit and three other Circuit Courts of Appeals as to whether there is an inherent conflict of interest when a plan insurer also administers plan benefits and to what extent that conflict mandates less deference be given to the plan's denial decision. While this Court in *Firestone* directed lower courts to factor into its discretion analysis any conflict of interest a fiduciary may have in making benefit decisions, there is now a tremendous need for this Court to clarify when such a conflict arises, whether the conflict can be inherent or presumed, and the

role such a conflict should play in the review of a benefit decision made by a conflicted fiduciary.

Dale Mers, the plan participant in this case, had every reason to expect that, under the language in Marriott's summary plan description, his wife and children would receive the benefits for which he paid premiums in the event of his accidental death. ERISA was enacted to promote and protect exactly this type of expectation in employee benefit plans and contractually-defined benefits. The Seventh Circuit's decision on rehearing in the present case, however, sets a precedent which seriously undermines the protections which ERISA sought to afford based not upon the statute's mandate but rather the court's own theory of "law and economics." This Court should take this opportunity to cure this serious erosion of the intent and purpose of ERISA.

For the foregoing reasons, Petitioner Pamela Hertel Mers respectfully requests that the petition for writ of certiorari be granted.

July 30, 1998

Respectfully submitted,

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IN THE
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

No. 97-1039

PAMELA HERTEL MERS

Plaintiff-Appellant,

v.

MARRIOTT INTERNATIONAL GROUP ACCIDENTAL DEATH AND DISMEMBERMENT PLAN,

Defendant-Appellee.

Appeal from the United States District Court
for the Northern District of Illinois, Eastern Division.
No. 95 C 7543 – **George M. Marovich,** *Judge.*

ARGUED OCTOBER 20, 1997 – DECIDED MAY 8, 1998*

Before BAUER, FLAUM, and KANNE, *Circuit Judges.*

KANNE, *Circuit Judge.* Mers appeals the district court's affirmance of Marriott International Group Accidental Death and Dismemberment Plan's denial of her claim for benefits. She asserts that two ERISA policies cover her husband's death. Because the denial was based

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* An opinion in this case was originally issued on February 24, 1998. Thereafter, on April 15, 1998, that opinion was vacated *sua sponte*. Because we overrule our prior precedent found in *Williams v. Midwest Operating Eng'rs Fund*, 125 F.3d 1138 (7th Cir. 1997), this opinion has been circulated pursuant to Circuit Rule 40(e). A majority of the active judges on the court did not favor a rehearing *en banc*. Circuit Judges Cummings and Rovner voted to grant rehearing *en banc*.

on a reasonable interpretation of the terms of both policies, we affirm the decision of the district court.

I. HISTORY

A.

Dale Mers worked for Marriott International, Inc. ("Marriott") as a Director of National Sales. On January 4, 1994, as part of his job, he attended a five-day conference sponsored by the Professional Convention Management Association. The kick-off for the conference was a volunteer project with Habitat for Humanity rehabilitating a home. Dale Mers was feeling well, but his participation in this project required an unusual amount of physical exertion for him. He used a sledge hammer and a crow-bar to tear down a plaster wall. While engaged in this activity, he complained of chest pains and collapsed.

Although he was rushed to a hospital, Dale Mers died early in the morning of January 6, 1994. At the time of his death, he was forty-four years old, had non-insulin diabetes, high cholesterol, and was approximately thirty to forty pounds overweight. However, he had never been treated for coronary or vascular problems nor been determined to have any problems with hypertension.

No autopsy was performed on Dale Mers because his family had his body cremated one day after his death. The death certificate listed the cause of death as cardiac arrest due to cerebral hemorrhage resulting from a brain stem infarction. In layman's terms, he had a heart attack because a blood vessel in his brain burst.

B.

The Marriott International Group Accidental Death and Dismemberment Plan ("Plan") is a welfare benefit plan that Marriott provides for its employees. It is governed by ERISA. *See* 29 U.S.C. § 1001 *et seq.* American International Group ("AIG"), a holding company that operates insurance companies through subsidiaries, is insurer of the Plan. A subsidiary of AIG issued policies insuring the Plan's benefits.

Marriott employees may choose from two types of accidental death and dismemberment coverages under the Plan. The first is a Business Travel Accident policy ("BTA") that Marriott provides automatically to every salaried employee. Dale Mers was eligible for $100,000 in benefits. The second is a 24-Hour Optional policy ("24-Hour") that Marriott offers to all salaried employees as additional coverage if the employee elects to enroll and pays premiums commensurate with the coverage amount selected. Dale Mers enrolled in the 24-Hour policy for $100,000 in benefits. Pamela Mers ("Mers") was her husband's designated beneficiary.

A summary plan document ("SPD") encapsulates the scope of coverage and exclusions for these policies. The BTA policy provides insurance protection if the insured should die or lose limbs, eyesight, speech, or hearing in an accident while traveling on Marriott business. The 24-Hour policy pays benefits if the insured suffers an accidental loss of life, limbs, eyesight, speech, or hearing at any time regardless of whether the person is engaged in Marriott business. Both policies exclude coverage for a loss caused by or resulting from disease of any kind.

Both policies also have the same definition of an injury. The policies define "injury" as "bodily injury caused by an accident . . . and resulting directly and independently of all other causes." The BTA policy has this definition only in its policy terms and not in the SPD; the 24-Hour policy has this definition in both locations.

C.

Shortly after Dale Mers' death, Marriott provided Mers with a copy of the SPD and a profile of benefits as of January 7, 1994. This profile stated that her husband had $100,000 in accidental death coverage. Unaware that her husband had enrolled in the 24-Hour policy, Mers assumed that this $100,000 coverage was under the BTA policy in which her husband was automatically enrolled.

In submitting Mers' claim to the Plan, however, Marriott erroneously included only a copy of Dale Mers' enrollment form for the 24-Hour policy. Marriott did not notify the Plan of Dale Mers' enrollment in the BTA policy and did not file a formal claim with the Plan for BTA benefits. Thus, the Plan considered only the terms of the 24-Hour policy in evaluating Mers' claim for benefits. The Plan was unaware that Mers had a potential claim for benefits under the BTA policy.

After Mers submitted a proof of claim form, Marriott forwarded it to American International Company ("AIC"), a subsidiary of AIG, to whom AIG had delegated its duties under the Plan. On August 3, 1994, AIC denied Mers' claim for benefits. Among other reasons, the letter cited the definition of injury found in the policies and the disease exception in concluding that the 24-

Hour policy did not cover Dale Mers' death. Under the terms of the 24-Hour policy, AIC concluded that an accident did not cause his death.

AIC based its determination on its investigation of the circumstances surrounding Dale Mers' death, its review of his medical records, and its receipt of the medical opinions of Drs. Daniel Hier and Jack Harnes. Dr. Hier concluded that the exertion that this job placed on Dale Mers, who was not used to performing physical labor, precipitated a sudden rise in blood pressure producing an intracerebral hemorrhage. Although Dr. Hier was unable to conclude whether an aneurysm or arteriosclerosis caused the localized weakening in the blood vessel's wall, Dr. Heir was able to conclude that Mers' participation in the Habitat project was not the sole cause of death. Dr. Harnes, AIC's medical consultant, also opined that the death was not independent of other causes. He concluded that arteriosclerosis resulting from Dale Mers' diabetes played a role in causing the blood vessel to rupture.

Mers appealed the Plan's denial. In support of her appeal, Mers submitted the medical opinion of Dr. Allan Aven. Dr. Aven's report discussed Dale Mers' activity just prior to his collapse and opined that the unusual and extreme physical exertion which Dale Mers experienced working on the Habitat for Humanity project precipitated his cerebral hemorrhage. Even though he argued that exertion was the primary cause of death, Dr. Aven conceded that cholesterol plaque or congenital dysplasia may have previously weakened a blood vessel sufficiently to cause it to rupture. Thus, Dr. Aven agreed with his colleagues that the acute hemorrhage was at least partially

the result of a ruptured cerebral aneurysm or a blood vessel weakened by arteriosclerosis. On December 8, 1994, AIC's appeals committee affirmed the denial of benefits.

D.

Mers filed a complaint on December 22, 1995 asserting that Marriott wrongfully denied her claim for benefits in violation of ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B). When the parties filed cross-motions for summary judgment, they realized that Mers could have asserted two claims, one under each policy. The court allowed Mers to amend her complaint. Both parties agreed that Mers never submitted a claim under the BTA policy for administrative review. The Plan offered to waive any timeliness defense, but Mers refused to proceed administratively, arguing that it would be futile. The district court agreed, reasoning that it would be extraordinarily wasteful and grossly inefficient to impose this requirement because the policies contain identical coverage and exclusion language. The court then addressed the merits of both claims.

The district court granted the Plan's motion for summary judgment, affirming the Plan's denial of Mers' claims. The court found that AIC, the plan insurer who made the denial decision, was operating under an inherent conflict of interest by serving both as the plan insurer and decision-maker. However, the lower court reviewed the denial under an arbitrary and capricious standard of review and held that the Plan's denial of benefits was reasonable because Dale Mers' death was not an "injury"

as defined in the insuring policies. The court also upheld the Plan's denial of benefits based on the exclusion of losses caused by or resulting from a disease.

Mers appealed to this Court.

II. ANALYSIS

A.

We review a district court's decision to grant summary judgment *de novo*. *See Buckley Dement, Inc. v. Travelers Plan Adm'rs, Inc.* 39 F.3d 784, 787 (7th Cir. 1994) (citing *Tolle v. Carrol Touch, Inc.*, 23 F.3d 174, 178 (7th Cir. 1994)). In performing this review, we analyze the record and controlling law under the same standard as the district court. *See Anweiler v. American Elec. Power Serv. Corp.*, 3 F.3d 986, 990 (7th Cir. 1993) (citing *Soo Line R. Co. v. Overton*, 992 F.2d 640, 643 (7th Cir. 1993)). Summary judgment is proper when "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c); *see also Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986). A fact is material only if it might affect the outcome of the case under the governing law. *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 249 (1986). To determine whether summary judgment is appropriate, we view the evidence and draw all reasonable inferences therefrom in a light favorable to the non-moving party. *See id.*

1.

In reviewing a denial of benefits under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), we look for guidance to the Supreme Court decision in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989). Analogizing ERISA's provisions to traditional rules of trust law, the Supreme Court held that "a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Id.* at 115. Where a plan confers power on the administrator to exercise discretion, the appropriate standard of review is the deferential "arbitrary and capricious" one. *See id*, at 111; *see also Donato v. Metropolitan Life Ins. Co.*, 19 F.3d 375, 379-80 (7th Cir. 1994).

In this case, we agree with the district court that the Plan gives AIG discretionary authority. In making that determination, we review the language of the Plan *de novo*, just as we would review the language of any contract. *See Bechtold v. Physicians Health Plans, Inc.*, 19 F.3d 322, 325 (7th Cir. 1994). The Plan names Marriott and AIG as fiduciaries with authority to control and manage the operation and administration of the Plan. The SPD, which sets forth the terms of both the BTA policy and the 24-Hour policy, gives Marriott sole, absolute, and final discretion to determine eligibility for benefits and to resolve any factual issues relevant to benefit eligibility or benefit enrollment. It also grants AIG sole, absolute, and final discretion to construe the terms of the Plan. No magic words are required to confer discretion. *See Donato*, 19 F.3d at 379. The terms of the Plan provide the fiduciaries

with discretionary authority. *See Chojnacki v. Georgia-Pacific Corp.*, 108 F.3d 810, 815 (7th Cir. 1997). As a result, we review Marriott's resolution of factual issues and AIG's construction of the terms of the Plan under the arbitrary and capricious standard of review.

2.

Mers argues that we should apply a more strict version of the arbitrary and capricious standard when an ERISA plan affords deference to a fiduciary that has a conflict of interest in awarding benefits.[1] Her theory is that an inherent conflict of interest exists when a company-sponsored plan allows an insurance company to interpret its own policies. She suggests that since an insurance company pays benefit claims out of its own assets, "its fiduciary role lies in perpetual conflict with its profit-making role as a business." *Brown v. Blue Cross & Blue Shield, Inc.*, 898 F.2d 1556, 1561 (11th Cir. 1990).

The district court concluded that AIC was operating under a conflict of interest. It afforded the Plan's decision less deference and viewed the Plan's decision to deny coverage for Dale Mers' death with greater suspicion. In making this determination, however, the district court

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[1] The arbitrary and capricious standard does not pose an all-or-nothing choice between full deference or none. Courts may vary the deference incrementally to account for the strength or weakness of a specific conflict of interest. *See Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048, 1049-52 (7th Cir. 1991).

presumed that Mers' request presented AIC with a conflict. Because we disagree with this presumption, we deny Mers' request for a reduction in deference.

While some courts have found that a denial of benefits is presumptively void and must be reviewed *de novo* where a similar conflict may exist, *see Brown*, 898 F.2d at 1561, we have not. *See Chalmers v. Quaker Oats Co.*, 61 F.3d 1340, 1344 (7th Cir. 1995); *Van Boxel*, 836 F.2d at 1048. We presume that a fiduciary is acting neutrally unless a claimant shows by providing specific evidence of actual bias that there is a significant conflict. *See Cuddington v. Northern Ind. Public Serv. Co.*, 33 F.3d 813, 816 (7th Cir. 1994); *Van Boxel*, 836 F.2d at 1051, 1053. The existence of a potential conflict is not enough. *See Cuddington*, 33 F.3d at 816. Mers has not established an actual conflict or a significant one. In fact, she offers no evidence that a conflict exists other than her theory of an inherent conflict. This production is not enough to show an actual bias.

Previously, we have rejected the theory that an inherent relational conflict is sufficient to alter the standard of review by applying a law-and-economics rationale to establish that no conflict exists. *See Chalmers*, 61 F.3d at 1344; *Van Boxel*, 836 F.2d at 1051. In *Chalmers*, Chalmers argued that because his company's severance program was an unfunded ERISA plan, i.e., not funded by salary withholdings, the committee that approved benefits had an automatic bias against dispensing severance benefits since those funds came directly from the company's earnings. *See* 61 F.3d at 1344. In affirming the denial of his claim, we held that the impact on the company's welfare of granting or denying benefits under a plan was not

sufficiently substantial to threaten an administrator's impartiality. *See id.*

For similar reasons, we find no inherent conflict of interest in this case. A decision to award Mers benefits would cost AIG $200,000. AIG has consistently been named as one of the fifty largest companies in the "Fortune 500" listing. The impact of granting or denying benefits in this case is minuscule compared to AIG's bottom line. *See id.* (noting that Quaker Oats, which generates revenue of nearly $6 billion annually, is "not likely to flinch at paying out $240,000"); *Van Boxel*, 836 F.2d at 1051 (recognizing that the amount may be "too slight to compromise the impartiality of the trustees").

Moreover, it is a poor business decision to resist paying meritorious claims for benefits. Companies like Marriott that sponsor ERISA plans are customers who choose which group insurance policies they will use to fund their plans. Mers and the Plan agree that these employers want to see their employees' claims granted because they want their employees satisfied with their fringe benefits. These corporate employers have the sophistication and bargaining power necessary to take their business elsewhere if an insurer like AIG consistently denies valid claims. In the long run, this type of practice would harm an insurer by inducing current customers to leave and by damaging its chances of acquiring new customers. *See Chalmers*, 61 F.3d at 1344 (finding a similar relationship between employers offering unfunded ERISA plans and their employees); *Van Boxel*, 836 F.3d at 1051 (same). Thus, no conflict of interest exists

because paying meritorious claims is in AIG's best interest. Since Mers has not established that AIG had a significant conflict of interest, we will reverse a denial of benefits only if the denial is arbitrary and capricious.[2]

B.

Mers contends that the district court erred by affirming the Plan's denial of benefits. She argues that the Plan acted arbitrarily and capriciously by incorporating a definition from the underlying policy that was not included in the SPD and by applying a disease exclusion where the evidence was insufficient to establish that Dale Mers suffered from a disease. For us to reverse the district court's grant of summary judgment for the Plan, Mers must succeed with both arguments as each determination by the Plan is a separate ground for denial. Because the Plan reasonably applied the definition of injury found in the policies, the district court did not err in affirming the Plan's denial of benefits.

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[2] Mers also argues that the district court erred in affording deference to AIC's factual determinations. More specifically, Mers claims that the Plan's delegation of its fiduciary duty to AIG voided any deference that the district court may owe the Plan's factual findings under the terms of the policies. Because we are affirming the denial of benefits on the independent ground that AIG reasonably interpreted the policies, we do not need to resolve this issue. To make our determination, we are not required to decide whether Dale Mers suffered from a pre-existing condition or a disease. We simply need to resolve whether the Plan reasonably concluded that the accident was not the sole cause of Dale Mers' death, and both parties agree that there were multiple causes.

1.

Under the arbitrary and capricious standard, it is not our function to decide whether we would reach the same conclusion as the Plan or even rely on the same authority. *See Cvelbar v. CBI Ill. Inc.*, 106 F.3d 1368, 1379 (7th Cir. 1997). We also will not set aside a plan's denial of benefits if the denial was based on a reasonable interpretation of the plan documents. *See Loyola Univ. v. Humana Ins. Co.*, 996 F.2d 985, 898 (7th Cir. 1993). Our role is to determine whether the decision was completely unreasonable. *See Chojnacki*, 108 F.3d at 816; *Van Boxel*, 836 F.2d at 1053.

ERISA requires that an SPD be "written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprize such participants and beneficiaries of their rights and obligations under the plan." 29 U.S.C. § 1022(a)(1). In particular, an SPD must list the circumstances in which disqualification, ineligibility, denial, or loss of benefits may occur. *See* 29 U.S.C. § 1022(b); 29 C.F.R. § 2520.102-3.

Mers claims the Plan acted arbitrarily and capriciously by relying on a definition of injury that is in the underlying policy but not in the SPD.[3] The existence of an SPD does not eviscerate the underlying policy. Our job is

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[3] This argument only applies against the BTA policy. While the district court was correct in concluding that the terms of the policies are the same, the 24-Hour policy includes the definition of injury in its SPD. This distinction, however, does not alter the policies in any material fashion. Thus, we agree with the lower court that it would be futile to require Mers to exhaust her administrative remedies.

to determine when the terms of the SPD control over the terms of the underlying policy.

We recently addressed this question in *Williams v. Midwest Operating Eng'rs Fund*, 125 F.3d 1138, 1140-41 (7th Cir. 1997). In that case, the SPD stated that it would cover hospital " 'charges for room and board . . . if required for hospitalization or treatment due to a non-occupational injury or illness.' " *Id.* at 1139 (quoting Summary at 12). The SPD excluded any illness or injury that was covered under workers' compensation, that was recoverable from a responsible third party, that resulted from an act of war, that affected anyone serving in the Armed Forces or any other government position, or that required treatment or services not prescribed by an eligible provider. *See id.* The SPD did not define the term "injury." However, the underlying plan defined injury as " 'bodily harm resulting from an accident. Accident as used in the foregoing, means an undesirable or unfortunate happening, unintentionally caused, resulting in harm.' " *Id.* at 1140 (quoting Plan at II-33).

In allowing Williams to rely on the SPD's terms over the plan's limitation, the court interpreted our case law which stated that "in the event of a discrepancy between the coverage promised in the summary plan document and that actually provided in the policy, [the insured] is entitled to claim the former.' " *Id.* at 1141 (quoting *Senkier v. Hartford Life & Accident Ins. Co.*, 948 F.2d 1050, 1051 (7th Cir. 1991)). We also referred to the holdings of other circuits that have addressed this issue. *See Hansen v. Continental Ins. Co.*, 940 F.3d 971, 982 (5th Cir. 1991)). (reasoning that "this Court holds that the summary plan description is binding, and that if there is a conflict

between the summary plan description and the terms of the policy, the summary plan description shall govern"); *Edwards v. State Farm Mut. Auto. Ins. Co.*, 851 F.2d 134, 136 (6th Cir. 1988) (holding that the SPD governs over the plan when there is a discrepancy); *McKnight v. Southern Life & Health Ins. Co.*, 758 F.2d 1566, 1570 (11th Cir. 1985) (same).

Because the plan's definition of injury incorporated a basis for denial of coverage that was not found in the SPD, the court agreed with Williams that the SPD should control. We then applied the common meaning of injury and estopped the Fund from using the Plan's language to deny Williams coverage. *See* 125 F.3d at 1141.

b.

Now, in retrospect, we erred in our *Williams* analysis in two ways. First, we did not decide whether the SPD in question satisfied ERISA's disclosure requirements. *See* 29 U.S.C. § 1992(a),(b) [sic]. While it is true that courts must fashion federal common law to govern ERISA suits in an effort to promote uniformity, *see Sullivan v. Cox*, 78 F.3d 322, 326 (7th Cir. 1996), we only turn to this common law when ERISA is silent on an issue, *see Phillips v. Lincoln Nat. Life Ins. Co.*, 978 F.2d 302, 311 (7th Cir. 1992). If an SPD does not satisfy ERISA's disclosure requirements, a court may estop a plan administrator from denying coverage for terms not included in the SPD but found in the underlying plan.[4]

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[4] If in *Williams* we had reviewed whether the SPD satisfies 29 U.S.C. § 1022, the same conclusion would have been reached

Second, we took an incorrect reading of our prior position on when terms of an SPD control over terms of the underlying policy.[5] *Williams* suggests that the terms of an SPD control over the terms of the underlying document if any discrepancy exists between them. *See id.* at 1141 (quoting *Senkier*, 948 F.2d at 1051). The *Williams* court found that a discrepancy exists when a definition provided only in the plan of a term used in the SPD is inconsistent with the common meaning of the term. *See id.* This interpretation of our precedent is not entirely accurate. We allow a participant or beneficiary to rely on

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without addressing whether the terms of the underlying plan contradicted or clarified the terms of the SPD. ERISA requires that SPD's list the circumstances in which disqualification, ineligibility, denial, or loss of benefits may occur and be "sufficiently accurate and comprehensive to reasonably apprise" participants and beneficiaries. *Id.* According to *Williams*, the plan's definition of injury incorporated a basis for denial of coverage – whether the injury resulted from an accident – that the SPD did not address. *See* 125 F.3d at 1141. Thus, we would have concluded that the SPD did not list all the circumstances where denial may occur. *See* 29 U.S.C. § 1022(b).

[5] We consider the *Williams* analysis to be a misstatement of our prior decisions and not an overruling. We require compelling reasons to overturn Circuit precedent. *See Mid-America Tablewares, Inc. v. Mogi Trading Co.*, 100 F.3d 1353, 1364 (7th Cir. 1996). Our general rule is to give considerable weight to our own decisions " 'unless and until they have been overruled or undermined by the decisions of a higher court, or other supervening developments, such as a statutory overruling.' " *Hass v. Abrahamson*, 910 F.2d 384, 292 (7th Cir. 1990)). (quoting *Colby v. J.C. Penney Co.*, 811 F.2d 1119, 1123 (7th Cir. 1987)). The court in *Williams* did not suggest that it was overruling our earlier approach and it did not provide a compelling reason for doing so. We therefore are not inclined to interpret its approach in that light.

the SPD and estop the plan administrator from denying coverage because of terms not included in the SPD only if there is a *direct conflict* between the SPD and the underlying policy. *See Senkier*, 948 F.2d at 1051; *Fuller v. CBT Corp.*, 905 F.2d 1055, 1060 (7th Cir. 1990).

In *Senkier*, we decided "whether a mishap in the course of treatment should be classified as part of the treatment itself or as an accident." 948 F.2d at 1051. The SPD in that case offered 24-hour protection against accidents anywhere in the world with the usual exclusions. *See id.* The SPD also referred the participant to the insurance policy itself for the details, and "the policy expressly exclude[d] not only 'sickness or disease' but also 'medical or surgical treatment of a sickness or disease.' " *Id.*

After realizing that our question did not depend on any specific provisions of ERISA, we exercised "our power to formulate federal common law principles suitable for the governance of pension and employee benefit trusts." *Id.* (citing *Fox Valley & Vicinity Constr. Workers Pension Fund v. Brown*, 897 F.2d 275, 281 (7th Cir. 1990) (*en banc*)). In doing so, we rejected Senkier's argument that the plan was estopped from denying coverage because she relied on the SPD, reasoning that:

> [I]n the event of a discrepancy between the coverage promised in the summary plan document and that actually provided in the policy, [an insured] is entitled to claim the former. . . .
>
> But only if there is a contradiction between the summary plan document and the policy. There is not [a contradiction] in a case such as this where the policy clarifies rather than contradicts the summary.

Id. Thus, in the Seventh Circuit, an SPD's silence on an issue does not estop a plan from relying on the more detailed policy terms when no direct conflict exist. *See Herrmann v. Cencom Cable Assocs., Inc.*, 978 F.2d 978, 983 (7th Cir. 1992) (allowing plan to enforce 45-day time limit contained in plan, despite its omission from the SPD, because an SPD does not prevail over the plan itself when the SPD is merely silent).

Moreover, we are not the only court to draw this distinction. While the circuits agree that an SPD controls if a conflict exists between the underlying policy and the SPD, see *Helwig v. Kelsey-Hayes Co.*, 93 F.3d 243, 247 (6th Cir. 1995); *Aiken v. Policy Management Systems Corp.*, 13 F.3d 138, 140 (4th Cir. 1993); *Hansen*, 940 F.3d at 982; *Alday v. Container Corp. Of Am.*, 906 F.2d 660, 666 (11th Cir. 1990), many of these courts also agree with us that this rule of construction should not be invoked if no direct conflict exists or if the SPD is silent on an issue that is described in the underlying policy, *see Sprague v. General Motors Corp.*, 133 F.3d 388 (6th Cir. 1998) (*en banc*) (holding that the principle that the terms of the SPD control when they conflict with the terms of the underlying plan does not apply when the SPD is merely silent on an issue because "[a]n omission from the summary plan description does not, by negative implication, alter the terms of the plan itself"); *Martin v. Blue Cross & Blue Shield of Va., Inc.*, 115 F.3d 1201, 1204 (4th Cir. 1997) (reasoning that underlying plan will control unless plaintiff can prove conflict between plan and SPD); *Jensen v. SIPCO, Inc.*, 38 F.3d 945, 952 (8th Cir. 1994) (holding that silence in an SPD does not override specific provisions in the underlying plan); *Wise v El Paso Nat. Gas. Co.*, 986 F.2d 929, 938

(5th Cir. 1993) ("While clear and unambiguous *statements* in the summary plan description are binding, the same is not true of silence.").

If silence in the SPD were enough to trump the underlying plan, then SPDs would mushroom in size and complexity until they mirrored the plans. "Larding the summary with minutiae would defeat that document's function: to provide a capsule guide in simple language for employees." *Herrmann*, 978 F.2d at 984; *see also Lorenzen v. Employees Ret. Plan of Sperry & Hutchinson Co.*, 896 F.2d 228, 236 (7th Cir. 1990) ("[A] plan summary is not required to anticipate every possible idiosyncratic contingency that might affect a particular participant's or beneficiary's status. . . . If it were, the summaries would be choked with detail and hopelessly confusing."). Clarity and completeness are competing goods. *See Lorenzen*, 896 F.2d at 236. We have accounted for these dueling considerations by allowing claimants to rely on an SPD when the policy terms contradict.

Thus, we reaffirm our pre-*Williams* position that, as long as an SPD satisfies ERISA's requirement that it is accurate and sufficiently comprehensive to reasonably apprise plan participants of their rights and obligations, *see* 29 U.S.C. § 1022, a participant or beneficiary may rely on an SPD and estop a plan administrator from denying coverage for terms found in the underlying policy only if there is a direct conflict between an SPD and the underlying policy. *See Hermann*, 978 F.2d at 983; *Senkier*, 948 F.2d at 1051; *Fuller*, 905 F.2d at 1060.

In this case, the SPD satisfies ERISA's disclosure requirements and the definition of injury in the underlying policy clarifies the terms of the SPD. The SPD for the BTA policy is accurate and sufficiently comprehensive to reasonably apprise its participants and beneficiaries. *See* 29 U.S.C. § 1022. It provides coverage for accidents and has an exclusion for a disease of any kind. Thus, the BTA policy does not cover circumstances when a disease is the sole cause of death.

The problem with this SPD is that it does not explain whether the Plan provides benefits in a situation where there are multiple causes for an accidental death. Both parties agree that multiple reasonable interpretations exist for when an accident triggers coverage; under the language of this SPD, the Plan could require an accident to be the sole cause, the predominant cause, or simply a contributing cause of death. The definition of injury found in the underlying policies resolves this question. The BTA policy defines an injury to mean bodily injury caused by an accident and resulting directly and independently of all other causes. This definition clarifies the question surrounding accidents with multiple causes. Because the definition clarifies and does not contradict the terms of the SPD, Mers cannot estop the Plan from denying coverage based on the clarifying terms of the underlying policies.

2.

Finally, we hold that AIC construed the definition of injury reasonably. All the medical evidence available suggests that Dale Mers' death did not result directly and

independently from his physical exertion. Although none of the doctors could state definitively whether it was an aneurysm or arteriosclerosis that assisted in causing the massive cerebral hemorrhaging, they all agreed that Dale Mers' physical exertion was not the only cause of death. Given this uncontroverted basis of factual support, it was reasonable for AIC to construe the definition of injury to prevent Mers from recovering benefits. The district court did not err in affirming the Plan's denial of benefits.

For all the above reasons, we AFFIRM the judgment of the district court.

A true Copy:

Teste:

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Clerk of the United States Court
of Appeals for the Seventh Circuit

IN THE
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

No. 97-1039

PAMELA HERTEL MERS

Plaintiff-Appellant,

v.

MARRIOTT INTERNATIONAL GROUP ACCIDENTAL DEATH AND DISMEMBERMENT PLAN,

Defendant-Appellee.

Appeal from the United States District Court
for the Northern District of Illinois, Eastern Division.
No. 95 C 7543 – **George M. Marovich,** *Judge.*

ARGUED OCTOBER 20, 1997 –
DECIDED FEBRUARY 24, 1998

Before BAUER, FLAUM, and KANNE, *Circuit Judges.*

KANNE, *Circuit Judge.* Mers appeals the district court's affirmance of Marriott International Group Accidental Death and Dismemberment Plan's denial of her claim for benefits. She asserts that two ERISA policies cover her husband's death. Because the denial was based on a reasonable interpretation of the terms of both policies, we affirm the decision of the district court.

I. HISTORY

A.

Dale Mers worked for Marriott International, Inc. ("Marriott") as a Director of National Sales. On January 4,

1994, as part of his job, he attended a five-day conference sponsored by the Professional Convention Management Association. The kick-off for the conference was a volunteer project with Habitat for Humanity rehabilitating a home. Dale Mers was feeling well, but his participation in this project required an unusual amount of physical exertion for him. He used a sledge hammer and a crow-bar to tear down a plaster wall. While engaged in this activity, he complained of chest pains and collapsed.

Although he was rushed to a hospital, Dale Mers died early in the morning of January 6, 1994. At the time of his death, he was forty-four years old, had non-insulin diabetes, high cholesterol, and was approximately thirty to forty pounds overweight. However, he had never been treated for coronary or vascular problems nor been determined to have any problems with hypertension.

No autopsy was performed on Dale Mers because his family had his body cremated one day after his death. The death certificate listed the cause of death as cardiac arrest due to cerebral hemorrhage resulting from a brain stem infarction. In layman's terms, he had a heart attack because a blood vessel in his brain burst.

B.

The Marriott International Group Accidental Death and Dismemberment Plan ("Plan") is a welfare benefit plan that Marriott provides for its employees. It is governed by ERISA. *See* 29 U.S.C. § 1001 *et seq.* American International Group ("AIG"), a holding company that operates insurance companies through subsidiaries, is

insurer of the Plan. A subsidiary of AIG issued policies insuring the Plan's benefits.

Marriott employees may choose from two types of accidental death and dismemberment coverages under the Plan. The first is a Business Travel Accident policy ("BTA") that Marriott provides automatically to every salaried employee. Dale Mers was eligible for $100,000 in benefits. The second is a 24-Hour Optional policy ("24-Hour") that Marriott offers to all salaried employees as additional coverage if the employee elects to enroll and pays premiums commensurate with the coverage amount selected. Dale Mers enrolled in the 24-Hour policy for $100,000 in benefits. Pamela Mers ("Mers") was her husband's designated beneficiary.

A summary plan document ("SPD") encapsulates the scope of coverage and exclusions for these policies. The BTA policy provides insurance protection if the insured should die or lose limbs, eyesight, speech, or hearing in an accident while traveling on Marriott business. The 24-Hour policy pays benefits if the insured suffers an accidental loss of life, limbs, eyesight, speech, or hearing at any time regardless of whether the person is engaged in Marriott business. Both policies exclude coverage for a loss caused by or resulting from disease of any kind.

Both policies also have the same definition of an injury. The policies define "injury" as "bodily injury caused by an accident . . . and resulting directly and independently of all other causes." The BTA policy has this definition only in its policy terms and not in the SPD; the 24-Hour policy has this definition in both locations.

C.

Shortly after Dale Mers' death, Marriott provided Mers with a copy of the SPD and a profile of benefits as of January 7, 1994. This profile stated that her husband had $100,000 in accidental death coverage. Unaware that her husband had enrolled in the 24-Hour policy, Mers assumed that this $100,000 coverage was under the BTA policy in which her husband was automatically enrolled.

In submitting Mers' claim to the Plan, however, Marriott erroneously included only a copy of Dale Mers' enrollment form for the 24-Hour policy. Marriott did not notify the Plan of Dale Mers' enrollment in the BTA policy and did not file a formal claim with the Plan for BTA benefits. Thus, the Plan considered only the terms of the 24-Hour policy in evaluating Mers' claim for benefits. The Plan was unaware that Mers had a potential claim for benefits under the BTA policy.

After Mers submitted a proof of claim form, Marriott forwarded it to American International Company ("AIC"), a subsidiary of AIG, to whom AIG had delegated its duties under the Plan. On August 3, 1994, AIC denied Mers' claim for benefits. Among other reasons, the letter cited the definition of injury found in the policies and the disease exception in concluding that the 24-Hour policy did not cover Dale Mers' death. Under the terms of the 24-Hour policy, AIC concluded that an accident did not cause his death.

AIC based its determination on its investigation of the circumstances surrounding Dale Mers' death, its review of his medical records, and its receipt of the medical opinions of Drs. Daniel Hier and Jack Harnes. Dr.

Hier concluded that the exertion that this job placed on Dale Mers, who was not used to performing physical labor, precipitated a sudden rise in blood pressure producing an intracerebral hemorrhage. Although Dr. Hier was unable to conclude whether an aneurysm or arteriosclerosis caused the localized weakening in the blood vessel's wall, Dr. Heir was able to conclude that Dale Mers' participation in the Habitat project was not the sole cause of death. Dr. Harnes, AIC's medical consultant, also opined that the death was not independent of other causes. He concluded that arteriosclerosis resulting from Dale Mers' diabetes played a role in causing the blood vessel to rupture.

Mers appealed the Plan's denial. In support of her appeal, Mers submitted the medical opinion of Dr. Allan Aven. Dr. Aven's report discussed Dale Mers' activity just prior to his collapse and opined that the unusual and extreme physical exertion which Dale Mers experienced working on the Habitat for Humanity project precipitated his cerebral hemorrhage. Even though he argued that exertion was the primary cause of death, Dr. Aven conceded that cholesterol plaque or congenital dysplasia may have previously weakened a blood vessel sufficiently to cause it to rupture. Thus, Dr. Aven agreed with his colleagues that the acute hemorrhage was at least partially the result of a ruptured cerebral aneurysm or a blood vessel weakened by arteriosclerosis. On December 8, 1994, AIC's appeals committee affirmed the denial of benefits.

D.

Mers filed a complaint on December 22, 1995 asserting that Marriott wrongfully denied her claim for benefits in violation of ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B). When the parties filed cross-motions for summary judgment, they realized that Mers could have asserted two claims, one under each policy. The court allowed Mers to amend her complaint. Both parties agreed that Mers never submitted a claim under the BTA policy for administrative review. The Plan offered to waive any timeliness defense, but Mers refused to proceed administratively, arguing that it would be futile. The district court agreed, reasoning that it would be extraordinarily wasteful and grossly inefficient to impose this requirement because the policies contain identical coverage and exclusion language. The court then addressed the merits of both claims.

The district court granted the Plan's motion for summary judgment, affirming the Plan's denial of Mers' claims. The court found that AIC, the plan insurer who made the denial decision, was operating under an inherent conflict of interest by serving both as the plan insurer and decision-maker. However, the lower court reviewed the denial under an arbitrary and capricious standard of review and held that the Plan's denial of benefits was reasonable because Dale Mers' death was not an "injury" as defined in the insuring policies. The court also upheld the Plan's denial of benefits based on the exclusion of losses caused by or resulting from a disease.

Mers appealed to this Court.

II. ANALYSIS

A.

We review a district court's decision to grant summary judgment *de novo*. *See Buckley Dement, Inc. v. Travelers Plan Adm'rs, Inc.* 39 F.3d 784, 787 (7th Cir. 1994) (citing *Tolle v. Carrol Touch, Inc.*, 23 F.3d 174, 178 (7th Cir. 1994)). In performing this review, we analyze the record and controlling law under the same standard as the district court. *See Anweiler v. American Elec. Power Serv. Corp.*, 3 F.3d 986, 990 (7th Cir. 1993) (citing *Soo Line R. Co. v. Overton*, 992 F.2d 640, 643 (7th Cir. 1993)). Summary judgment is proper when "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c); *see also Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986). A fact is material only if it might affect the outcome of the case under the governing law. *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 249 (1986). To determine whether summary judgment is appropriate, we view the evidence and draw all reasonable inferences therefrom in a light favorable to the non-moving party. *See id.*

1.

In reviewing a denial of benefits under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), we look for guidance to the Supreme Court's decision in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989). Analogizing ERISA's provisions to traditional rules of trust law, the

Supreme Court held that "a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Id.* at 115. Where a plan confers power on the administrator to exercise discretion, the appropriate standard of review is the deferential "arbitrary and capricious" one. *See id*, at 111; *see also Donato v. Metropolitan Life Ins. Co.*, 19 F.3d 375, 379-80 (7th Cir. 1994).

In this case, we agree with the district court that the Plan gives AIG discretionary authority. In making that determination, we review the language of the Plan *de novo*, just as we would review the language of any contract. *See Bechtold v. Physicians Health Plans, Inc.*, 19 F.3d 322, 325 (7th Cir. 1994). The Plan names Marriott and AIG as fiduciaries with authority to control and manage the operation and administration of the Plan. The SPD, which sets forth the terms of both the BTA policy and the 24-Hour policy, gives Marriott sole, absolute, and final discretion to determine eligibility for benefits and to resolve any factual issues relevant to benefit eligibility or benefit enrollment. It also grants AIG sole, absolute, and final discretion to construe the terms of the Plan. No magic words are required to confer discretion. *See Donato*, 19 F.3d at 379. The terms of the Plan provide the fiduciaries with discretionary authority. *See Chojnacki v. Georgia-Pacific Corp.*, 108 F.3d 810, 815 (7th Cir. 1997). As a result, we review Marriott's resolution of factual issues and AIG's construction of the terms of Plan under the arbitrary and capricious standard of review.

2.

Mers argues that we should apply a more strict version of the arbitrary and capricious standard when an ERISA plan affords deference to a fiduciary that has a conflict of interest in awarding benefits.[1] Her theory is that an inherent conflict of interest exists when a company-sponsored plan allows an insurance company to interpret its own policies. She suggests that since an insurance company pays benefit claims out of its own assets, "its fiduciary role lies in perpetual conflict with its profit-making role as a business." *Brown v. Blue Cross & Blue Shield, Inc.*, 898 F.2d 1556, 1561 (11th Cir. 1990).

The district court concluded that AIC was operating under a conflict of interest. It afforded the Plan's decision less deference and viewed the Plan's decision to deny coverage for Dale Mers' death with greater suspicion. In making this determination, however, the district court presumed that Mers' request presented AIC with a conflict. Because we disagree with this presumption, we deny Mers' request for a reduction in deference.

While some courts have found that a denial of benefits is presumptively void and must be reviewed *de novo* where a similar conflict may exist, *see Brown*, 898 F.2d at 1561, we have not. *See Chalmers v. Quaker Oats Co.*, 61 F.3d 1340, 1344 (7th Cir. 1995); *Van Boxel*, 836 F.2d at 1048. We

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[1] The arbitrary and capricious standard does not pose an all-or-nothing choice between full deference or none. Courts may vary the deference incrementally to account for the strength or weakness of a specific conflict of interest. *See Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048, 1049-52 (7th Cir. 1991).

presume that a fiduciary is acting neutrally unless a claimant shows by providing specific evidence of actual bias that there is a significant conflict. *See Cuddington v. Northern Ind. Public Serv. Co.*, 33 F.3d 813, 816 (7th Cir. 1994); *Van Boxel*, 836 F.2d at 1051, 1053. The existence of a potential conflict is not enough. *See Cuddington*, 33 F.3d at 816. Mers has not established an actual conflict or a significant one. In fact, she offers no evidence that a conflict exists other than her theory of an inherent conflict. This production is not enough to show an actual bias.

Previously, we have rejected the theory that an inherent relational conflict is sufficient to alter the standard of review by applying a law-and-economics rationale to establish that no conflict exists. *See Chalmers*, 61 F.3d at 1344; *Van Boxel*, 836 F.2d at 1051. In *Chalmers*, Chalmers argued that because his company's severance program was an unfunded ERISA plan, i.e., not funded by salary withholdings, the committee that approved benefits had an automatic bias against dispensing severance benefits since those funds came directly from the company's earnings. *See* 61 F.3d at 1344. In affirming the denial of this claim, we held that the impact on the company's welfare of granting or denying benefits under a plan was not sufficiently substantial to threaten an administrator's impartiality. *See id.*

For similar reasons, we find no inherent conflict of interest in this case. A decision to award Mers benefits would cost AIG $200,000. AIG has consistently been named as one of the fifty largest companies in the "Fortune 500" listing. The impact of granting or denying benefits in this case is minuscule compared to AIG's

bottom line. *See id.* (noting that Quaker Oats, which generates revenue of nearly $6 billion annually, is "not likely to flinch at paying out $240,000"); *Van Boxel*, 836 F.2d at 1051 (recognizing that the amount may be "too slight to compromise the impartiality of the trustees").

Moreover, it is a poor business decision to resist paying meritorious claims for benefits. Companies like Marriott that sponsor ERISA plans are customers who choose which group insurance policies they will use to fund their plans. Mers and the Plan agree that these employers want to see their employees' claims granted because they want their employees satisfied with their fringe benefits. These corporate employers have the sophistication and bargaining power necessary to take their business elsewhere if an insurer like AIG consistently denies valid claims. In the long run, this type of practice would harm an insurer by inducing current customers to leave and by damaging its chances of acquiring new customers. *See Chalmers*, 61 F.3d at 1344 (finding a similar relationship between employers offering unfunded ERISA plans and their employees); *Van Boxel*, 836 F.3d at 1051 (same). Thus, no conflict of interest exists because paying meritorious claims is in AIG's best interest. Since Mers has not established that AIG had a significant conflict of interest, we will reverse a denial of benefits only if the denial is arbitrary and capricious.[2]

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[2] Mers also argues that the district court erred in affording deference to AIC's factual determinations. More specifically, Mers claims that the Plan's delegation of its fiduciary duty to AIG voided any deference that the district court may owe the Plan's factual findings under the terms of the policies. Because we are affirming the denial of benefits on the independent

B.

Mers contends that the district court erred by affirming the Plan's denial of benefits. She argues that the Plan acted arbitrarily and capriciously by incorporating a definition from the underlying policy that was not included in the SPD and by applying a disease exclusion where the evidence was insufficient to establish that Dale Mers suffered from a disease. For us to reverse the district court's grant of summary judgment for the Plan, Mers must succeed with both arguments as each determination by the Plan is a separate ground for denial. Because the Plan reasonably applied the definition of injury found in the policies, the district court did not err in affirming the Plan's denial of benefits.

1.

Under the arbitrary and capricious standard, it is not our function to decide whether we would reach the same conclusion as the Plan or even rely on the same authority. *See Cvelbar v. CBI Illinois Inc.*, 106 F.3d 1368, 1379 (7th Cir. 1997). We also will not set aside a plan's denial of benefits if the denial was based on a reasonable interpretation of the plan documents. *See Loyola Univ. v. Humana Ins. Co.*, 996 F.2d 985, 898 (7th Cir. 1993). Our role is to determine

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ground that AIG reasonably interpreted the policies, we do not need to resolve this issue. To make our determination, we are not required to decide whether Dale Mers suffered from a pre-existing condition or a disease. We simply need to resolve whether the Plan reasonably concluded that the accident was not the sole cause of Dale Mers' death, and both parties agree that there were multiple causes.

whether the decision was completely unreasonable. *See Chojnacki*, 108 F.3d at 816; *Van Boxel*, 836 F.2d at 1053.

ERISA requires that a summary be "written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan." 29 U.S.C. § 1022(a)(1). In particular, a summary must list the circumstances in which disqualification, ineligibility, denial, or loss of benefits may occur. *See* 29 U.S.C. § 1022(b); 29 C.F.R. § 2520.102-3.

Mers claims the Plan acted arbitrarily and capriciously by relying on a definition of injury that is in the underlying policy but not in the SPD.[3] The existence of an SPD, however, does not preclude the use of every term in the underlying policy. ERISA entitles Mers to rely on the SPD and estop the Plan from denying coverage because of terms not included in the SPD only if there is a *contradiction* between the SPD and the underlying policy. *See Senkier v. Hartford Life & Acc. Ins. Co.*, 948 F.2d 1050, 1051 (7th Cir. 1991). A plan is not estopped from incorporating terms from the underlying policy where they clarify rather than contradict the summary. *See id.* at 1051. An SPD's silence on an issue or ambiguity of its terms does

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[3] This argument only applies against the BTA policy. While the district court was correct in concluding that the terms of the policies are the same, the 24-Hour policy includes the definition of injury in its SPD. This distinction, however, does not alter the policies in any material fashion. Thus, we agree with the lower court that it would be futile to require Mers to exhaust her administrative remedies.

not estop a plan from relying on more detailed plan terms when no direct conflict exists. *See Hermann v. Cencom Cable Assocs., Inc.*, 978 F.2d 978, 983 (7th Cir. 1992) (allowing plan to enforce 45-day time limit contained in plan, despite its omission from the SPD, because an SPD does not prevail over the plan itself when the SPD is merely silent); *Senkier*, 948 F.2d at 1051 (allowing estoppel "only if there is a contradiction"); *Gaspar v. Linvatec Corp.*, 952 F. Supp. 1274, 1280 (N.D. Ill. 1997) (requiring actual conflicts between a plan and the plan's SPD); *Kyles v. Northwestern Univ.*, No. 91 C 7860, 1993 WL 369342, at *7 (N.D. Ill. Sept. 17, 1993) ("A summary that does not make any reference to a matter covered in the underlying policy cannot be said to conflict with or contradict the policy.").

In this matter, the definition of injury in the policies clarifies the terms of the SPD. The BTA policy provides coverage for accidents. It also has an exclusion for a disease of any kind. Thus, it is undisputed that the BTA policy does not cover circumstances when a disease is the cause of death.

The problem with this SPD is that it does not explain whether the Plan provides benefits in a situation where there are multiple causes for an accidental death. Both parties agree that multiple reasonable interpretations exist for when an accident triggers coverage; under the language of the SPD, the Plan could require an accident to be the sole cause, the predominant cause, or simply a contributing cause of death. The definition of injury found in the underlying policies resolves this question. The BTA policy defines an injury to mean bodily injury caused by an accident and resulting directly and independently of all other causes. This definition clarifies the

ambiguity surrounding accidents with multiple causes. Because the definition clarifies and does not contradict the terms of the SPD, the Plan is not estopped from relying on it. We therefore reject Mers' contention otherwise.

Mers also suggests there is a contradiction because there is coverage if the SPD stands alone, but there is no coverage if the policy and the SPD are read together. We refuse this suggestion as simply a reformulation of the argument that beneficiaries should be able to use only the SPD and never consider whether additional terms exist. This position is counter to the purpose of an SPD. *See Hermann*, 978 F.2d at 983-84 (concluding that no document can include every detail and remain a summary); *Lorenzen v. Employees Ret. Plan of Sperry & Hutchinson Co.*, 896 F.2d 228, 236 (7th Cir. 1990) ("[A] plan summary is not required to anticipate every possible idiosyncratic contingency that might affect a particular participant's or beneficiary's status. . . . If it were, the summaries would be choked with detail and hopelessly confusing."). Clarity and completeness are competing goods. *See Lorenzen*, 896 F.2d at 236. We have accounted for these dueling considerations by allowing claimants to rely on an SPD when the policy terms contradict. Because they do not here, Mers cannot estop the Plan from denying coverage based on the clarifying terms of the underlying policies.

2.

Finally, we hold that AIC construed the definition of injury reasonably. All the medical evidence available suggests that Dale Mers' death did not result directly and

independently from his physical exertion. Although none of the doctors could state definitely whether it was an aneurysm or arteriosclerosis that assisted in causing the massive cerebral hemorrhaging, they all agreed that Dale Mers' physical exertion was not the only cause of death. Given this uncontroverted basis of factual support, it was reasonable for AIC to construe the definition of injury to prevent Mers from recovering benefits. The district court did not err in affirming the Plan's denial of benefits.

For all the above reasons, we AFFIRM the judgment of the district court.

A true Copy:

Teste:

Clerk of the United States Court
of Appeals for the Seventh Circuit

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
– EASTERN DIVISION

PAMELA HERTEL MERS, Plaintiff, v. MARRIOTT INTERNATIONAL GROUP ACCIDENTAL DEATH AND DISMEMBERMENT PLAN, MARRIOTT INTERNATIONAL, INC., AMERICAN INTERNATIONAL GROUP, and AMERICAN INTERNATIONAL COMPANIES, Defendants.	)	No. 95 C 7543 Judge George M. Marovich

MEMORANDUM OPINION AND ORDER

Plaintiff Pamela Hertel Mers ("Mers") asserts that Defendant Marriott International Group Accidental Death and Dismemberment Plan (the "Plan") wrongfully denied her claim for benefits under the Plan's Business Travel Accident Insurance Policy, in which Mers' deceased husband, Dale Mers, was enrolled. Accordingly, in Count I of her Complaint, Mers seeks payment of those benefits from the Plan pursuant to Section 502(a)(1)(B) of the Employee Retirement Security Income Act ("ERISA"), 29 U.S.C. § 1132(a)(1)(B).[1] Now before the Court are the

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[1] Mers originally attempted to assert claims against the Plan, Marriott International, Inc. ("Marriott"), American International Group ("AIG") and American International Companies ("AIC") for breach of fiduciary duty in violation of

parties' cross-motions for summary judgment. For the reasons set forth below, the Court grants the Plan's, and denies Mers', summary judgment motion.

BACKGROUND

The following facts, taken from the parties Local Rule 12(M) and 12(N) statements, are largely undisputed by the parties. The Plan is a welfare-benefit plan provided by Marriott for its employees; the Plan is subject to, and governed by, ERISA. The Plan offers Marriott employees two types of accidental death insurance policies: (1) a Business Travel Accident policy (the "BTA Policy") that provides protection for death or dismemberment resulting from an accident while an employee is travelling on company business; and (2) an Optional 24-Hour Policy (the "24-Hour Policy") that provides round-the-clock protection for death or dismemberment resulting from an accident, regardless of whether the employee is travelling on company business at the time of his or her injury.

All full-time Marriott employees automatically are enrolled in the BTA Policy – those employees earning $30,000 or more per year being eligible for up to $100,000 in benefits, and those employees earning less than $30,000 per year being eligible for up to $50,000 in benefits. Enrollment in the 24-Hour Policy is not automatic, however; interested employees must authorize premium

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ERISA. By orders dated April 26, 1996 and June 19, 1996, however, this Court dismissed those claims – Counts II and III of Mers' Complaint – pursuant to Fed. R. Civ. P. 12(b)(6). Thus, only Mers' Count I, ERISA claim for wrongful denial of benefits under Policy remains.

deductions from their paychecks in order to obtain coverage.

Dale Mers was employed by Marriott as a Director of National Accounts. As a full-time Marriott employee earning more than $30,000 a year, Dale Mers was enrolled automatically in the BTA Policy and was eligible for up to $100,000 in benefits under that policy. Dale Mers also enrolled in the 24-Hour Policy for up to $100,000 in benefits; premiums for the 24-Hour Policy were regularly deducted from Dale Mers' paycheck. Mers was her husband's designated beneficiary.

On January 5, 1994, Dale Mers checked into a Chicago hotel to attend a five-day conference of the Professional Convention Management Association ("PCMA"). Dale Mers' PCMA dues were paid by Marriott and his involvement in the organization and attendance at the conference were undertaken in furtherance of Marriott's business. As part of the PCMA conference, Dale Mers participated in a Habitat for Humanity project on January 5, using a sledge hammer and crow-bar to tear down a plaster and lath wall. While engaged in this strenuous activity, Dale Mers collapsed. He died the next day, January 6, 1994, at St. Francis Hospital. Dale Mers' death certificate lists the cause of death as cardiac arrest due to, or as a consequence of, cerebral hemorrhage; no autopsy was performed. At the time of his death, Dale Mers was 44 years old, was feeling well, and, other than suffering from mild, non-insulin diabetes, was in good physical health.

Soon after Dale Mers' death, Mers was told by Marriott that her husband possessed only $100,000 in accidental death coverage. Mers, allegedly unaware that her husband had enrolled in the 24-Hour Policy, assumed this $100,000 coverage to be under the BTA Policy.

On or about March 2, 1994, Mers, following the procedures set forth in the Summary Plan Description, filed a claim for benefits with Marriott. Marriott apparently delegated responsibility for resolving factual questions and determining Mers' eligibility for Plan benefits to AIC (a subsidiary of AIG, the Plan's insurer), who, in turn, retained the services of Equifax, a claims service.

In submitting Mers' claim to the Plan, Marriott included only a copy of Dale Mers' enrollent form for the 24-Hour Policy. Marriott errantly failed to notify the Plan of Dale Mers' enrollment in the BTA Policy and did not file a formal claim with the Plan for BTA Policy benefits. Thus, in evaluating Mers' claim for benefits, the Plan considered only the terms of the 24-Hour Policy; the Plan did not realize that Mers had a potential claim for benefits under the BTA Policy.

On August 3, 1994, AIC wrote Per K. Hanson ("Hanson"), Mers' attorney, and advised him that, based upon its investigation of the circumstances surrounding Dale Mers' death, its review of Dale Mers' medical records, and its receipt of the medical opinions of Drs. Daniel Hier, M.D. and Jack Harnes, M.D., AIC had concluded that Mers was ineligible for benefits under the terms of the Plan. Specifically, AIC informed Hanson that, "In so far [sic] as Mr. Mers' exertion exacerbated a preexisting condition [an intracranial aneurysm], we must

conclude that Mr. Mers' death was not independent of all other causes of loss." (Ex. 7, Def. 12 (M) Statement, p. 2.).

Mers appealed the Plan's denial and submitted for the Appeals Committee's consideration a September 16, 1994 letter from Dr. Allan B. Aven, M.D., S.C., who stated as follows:

> This individual performed a series of extremely physically demanding activities during which increased vascular pressures were transmitted from the abdomen and chest into the vascular system of the brain (a Valsalva maneuver). This may have caused a blood vessel, previously weakened (by cholesterol plaque or congenital dysplasia) to rupture. On the other hand, had this person continued in his usual and customary lifestyle, the vascular rupture would not have suddenly happened.

(Ex. 4, Def. 12(M) Statement, p. 1.) AIC forwarded Dr. Aven's letter to Dr. Harnes, AIC's medical consultant, for review. Dr. Harnes reported back to AIC that, "Dr. Aven argues that a pre-existing condition, aggravated by exertion, caused [Dale Mers'] hemorrhage. Since the hemorrhage would thus not be independent of the pre-existing disease hypothesized by Dr. Aven, I fail to see why his letter should change our position." (Ex. 12, Def. 12(M) Statement.)

Based upon its review of the full administrative record, the Appeals Committee re-affirmed the denial of benefits to Mers under the 24-Hour Policy. Mers was informed on [sic] the Appeals Committee's decision by letter dated December 8, 1994.

Mers filed her Complaint with this Court on December 22, 1995. After much initial confusion, both parties now agree that Mers' Count I seeks payment of benefits only under the BTA Policy. On August 29, 1996, the Plan filed its motion for summary judgment, asserting that (1) Mers' claim is premature, as she failed to exhaust her administrative remedies by filing a claim under the BTA Policy with the Plan; or, alternatively, (2) because the Plan's determination that Dale Mers' death did not result independently of all other causes of loss was not "downright unreasonable," the Plan's denial of benefits must be affirmed, as a matter of law, using the deferential, "abuse of discretion" standard of review. On September 26, 1996, Mers filed her motion for summary judgment, contending that (1) given AIC's inherent conflict of interest in evaluating Mers' claim for benefits, the Plan's denial must be reviewed *de novo*, rather than under an "arbitrary and capricious" standard; and (2) because Dale Mers' death was caused by his unusually strenuous work activity at the Habitat for Humanity project and was wholly unexpected and unforeseeable, his death constitutes an "accident" within the meaning of the BTA Policy – an accident for which she is entitled, as a matter of law, to payment of benefits.

DISCUSSION

A. Standards for Summary Judgment

Summary judgment is appropriate where the pleadings, answers to interrogatories, admissions, affidavits, and other materials show that there is "no genuine issue as to any material fact," and the moving party is entitled

to judgment as a matter of law. Fed. R. Civ. P. 56(c). Only genuine disputes over "material facts" can prevent a grant of summary judgment. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). "Material facts" are those that might affect the outcome of the suit under governing law. *Id.* A "genuine issue" exists if there is "sufficient evidence favoring the non-moving party for a jury to return a verdict for that party." *Id.* at 249. When considering a motion for summary judgment, the Court must view the facts, and all the inferences drawn from those facts, in the light most favorable to the nonmovant. *Griffin v. Thomas*, 929 F.2d 1210, 1212 (7th Cir. 1991); *Roman v. U.S. Postal Service*, 821 F.2d 382, 385 (7th Cir. 1987).

B. Mers' Failure To Exhaust Her Administrative Remedies

The parties agree that Mers has failed to exhaust her administrative remedies, as Mers (through circumstances arguably beyond her control) never has presented her claim for benefits under the BTA Policy to the Plan fiduciaries and/or administrator for consideration. Exhaustion of administrative remedies prior to filing suit generally is required because it (1) "enhances the ability of plan fiduciaries to expertly and efficiently manage their plans by preventing premature judicial intervention," *Powell v. AT&T Comm., Inc.*, 938 F.2d 823, 826 (7th Cir. 1991); (2) assists the courts by ensuring that a plaintiff's claims have been "fully considered" by plan fiduciaries, *Id.*; and (3) "gives effect to Congress' apparent intent, in mandating internal claims procedures, to minimize the number

of frivolous lawsuits, to promote consistent treatment of claims, to provide a nonadversarial dispute resolution process, and to decrease the cost and time of claims settlement." *Wilczynski v. Lumbermens Mutual Cas. Co.*, 93 F.3d 397, 402 (7th Cir. 1996). Consequently, the Seventh Circuit has made clear that "application of the exhaustion doctrine . . . is a matter within the discretion of the trial court," and that "as a matter of sound policy [the court] should usually [apply it]." *Kross v. Western Elec. Co., Inc.*, 701 F.2d 1238, 1244-45 (7th Cir. 1983). Yet, courts should not, and generally will not, invoke the exhaustion doctrine to dismiss a claim for benefits where utilizing a Plan's internal procedures would yield an inadequate remedy or where pursuing administrative avenues would be, at best, a futile gesture. *See Smith v. Blue Cross & Blue Shield United of Wis.*, 959 F.2d 655, 658-59 (7th Cir. 1992); *Dale v. Chicago Tribune Co.*, 797 F.2d 458, 466 (7th Cir. 1986).

Here, there can be little doubt that any effort by Mers to recover benefits under the BTA Policy directly from the Plan would be futile. The Plan makes abundantly clear in its various briefs and in its statements to this Court that it would have denied (and, if given the opportunity, will deny) Mers' claim under the BTA Policy, as that policy contains the identical basic coverage and exclusion language on which the Plan based its denial of benefits under the 24-Hour policy. Thus, it would be extraordinarily wasteful and grossly inefficient to dismiss Mers' suit at this late stage and to require Mers to present her BTA Policy claim to the Plan fiduciary; the Plan's position is certain and, by its own admission, unwavering – Mers cannot recover benefits from the Plan for Dale Mers'

death because his death was not caused by an accident, independent of all other causes.

C. Appropriate Standard For Reviewing The Plan's Denial Of Benefits

Actions challenging the denial of benefits under ERISA Section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), are subject to the standard of review announced in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989). In *Firestone*, the Supreme Court observed that "a denial of benefits challenged under Section 1132(a)(1)(B) is to be reviewed under a *de novo* standard." *Firestone*, 489 U.S. at 113. Where, however, discretion to interpret ERISA plan terms is reserved by, or delegated to, a plan administrator or fiduciary, courts are required to review those interpretations applying an "arbitrary and capricious" standard. *Id.*; *Pagan v. NYNEX Pension Plan*, 53 F.3d 438, 441 (2d Cir. 1995). The Seventh Circuit recently said about *Firestone*:

> [T]he court announced that the arbitrary and capricious standard of review was to be replaced by de novo review unless the terms of the agreement granted the fiduciary discretion in the award or denial of benefits. . . . When the fiduciary has discretion, we review its decisions for abuse. . . . As in trusts law, whether something constitutes an abuse depends on the terms of the instrument; the more discretion that is conferred upon the trustee or fiduciary, the more deference the consequent decision is entitled. . . . [When] the amount of discretion is virtually unconstrained, the court should review the decision under an arbitrary and capricious standard. . . . Under that standard we evaluate

> several factors: The impartiality of the decision making body, the complexity of the issues, the process afforded the parties, the extent to which the decision makers utilized the assistance of experts where necessary, and finally the soundness of the fiduciary's ratiocination.

Chalmers v. Quaker Oats Co., 61 F.3d 1340, 1343-44 (7th Cir. 1995).

The parties agree that Marriott is the Plan sponsor, that Marriott and AIG are the Plan's named fiduciaries, and that the Corporate Benefits Department of Marriott is the Plan Administrator. The parties further recognize that the Summary Plan Description, which sets forth the terms of both the BTA Policy and the 24-Hour Policy, (1) gives Marriott "sole, absolute and final discretion to determine eligibility for benefits and to resolve any factual issues relevant to benefit eligibility or benefit enrollment"; and (2) grants AIG "sole, absolute and final discretion to deny to construe the terms of the Plan." (Ex. H, Pltf. 12 (M) Statement, p.3). Thus, this Court must review the Plan's decision to deny coverage for Dale Mers' death under the deferential "arbitrary and capricious" standard.

While Mers maintains that her present claim should be reviewed *de novo* because the Plan was never presented with, and, thus, did not specifically deny, a claim for benefits under the BTA Policy, Mers conveniently ignores the fact that the Plan denied her claim under the 24-Hour Policy based upon its conclusion that Dale Mers' death was not caused by an accident, independent of other causes – a conclusion that similarly bars payment of benefits under the basic coverage and exclusionary language of the BTA Policy. Indeed, in her successful effort

to side-step application of the administrative exhaustion doctrine to her present action, Mers explicitly recognizes that the formal presentation of a claim under the BTA Policy would be futile in light of AIG's stated interpretation of the Plan's terms and its unequivocal resolution of the factual issues pertaining to Dale Mers' death. Hence, the Plan's decision to deny coverage under the 24-Hour Policy effectively operates to deny coverage under the BTA Policy, and, as a result, Mers' present claim – a claim that necessarily requires this court to review the propriety of the Plan's decision under the 24-Hour Policy – is subject to the "arbitrary and capricious" standard of review.[2]

Mers correctly points out, however, that this Court should afford less deference to, and should view with greater suspicion, the Plan's decision to deny coverage for Dale Mers' death because AIC was operating under a conflict of interest when it denied Mers' claim. As previously indicated, AIC – the company to whom Marriott delegated resonsibility for resolving factual questions and determining eligibility for benefits – is a subsidiary

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[2] It should be noted that if Mers were now seriously to contend either that the Plan's factual conclusions do not operate to preclude Mers' recovery under the BTA Policy or that the Plan might consider certain matters, apply different factors, and/or interpret different terms with respect to a claim under the BTA Policy than it did with respect to Mers' claim under the 24-Hour Policy, then a formal request by Mers to the Plan for benefits under the BTA Policy would not be futile, and, accordingly, the Court would dismiss Mers' present claim for her failure to exhaust her administrative remedies.

of AIG – the Plan's insurer. Consequently, the Court presumes that AIC, when considering Mers' request for benefits, was, in fact, presented with a conflict of interest:

> Courts have found substantial potential for conflict to exist where a plan administrator or fiduciary serves the dual roles of a decision-maker with regard to the granting or denial of claims and an insurer "which must constantly strive to make its revenues exceed its costs."

Velez v. Prudential Health Care Plan of New York, Inc., 1966 WL 633721, at *5 (S.D.N.Y. Oct. 18, 1996) (quoting *Brown v. Blue Cross & Blue Shield of Alabama, Inc.*, 898 F.2d 1556, 1561 (11th Cir. 1990)).

Yet, AIC's inherent conflict does not, as Mers' contends, change the standard of review from arbitrary and capricious to *de novo*; rather, it merely is a factor to be considered in determining whether the Plan abused its discretion in denying Mers' benefit claim. As explained by the Seventh Circuit:

> [F]lexibility in the scope of judicial review need not require a proliferation of different standards of review; the arbitrary and capricious standard may be a range, not a point. There may be in effect a sliding scale of judicial review of trustees' decisions – more penetrating the greater the suspicion of partiality, less penetrating the smaller that suspicion is.

Van Boxel v. Journal Co. Employees' Pension Trust, 836 F.2d 1048, 1052 (7th Cir. 1987); *see also Velez*, 1996 WL 633721, at *5-6; *Swaback v. American Information Tech. Corp.*, 1995

WL 769784, at *7 (N.D. Ill. Dec. 29, 1995); *Kost v. Prudential Ins. Co. of America*, 1995 WL 359934, at *1 (N.D. Ill. June 13, 1995).

D. Reasonableness of The Plan's Decision To Deny Coverage

Regardless of the degree of deference that should be afforded the Plan's decision, Mers has the initial burden of showing that the Plan's conclusions are legally and/or factually wrong and that Dale Mers' death falls within the terms of the policy. *See Van Boxel*, 836 F.2d at 1053 ("[t]he greater the conflict of interest . . . the less we defer to a denial of benefits that appears to be wrong"); *Brown*, 898 F.2d at 1556 ("[i]t is fundamental that the fiduciary's interpretation first must be 'wrong' from the perspective of *de novo* review before a reviewing court is concerned with the self-interest of the fiduciary"); *see also Wahls v. Aetna Life Ins. Co.*, 122 Ill. App. 3d 309, 311, 461 N.E.2d 466 (1984) ("plaintiff has the burden of proving that decedent died as a result of an accidental bodily injury within the terms of the subject policy.").[3] Both the 24-Hour Policy and the BTA Policy clearly state that their coverage applies only to "injury,"[4] and both policies define "injury" as follows:

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[3] Significantly, the interpretation of an insurance policy presents a question of law to be decided by the Court. *Cincinnati Ins. Co. v. Flanders Electric Motor Service, Inc.*, 40 F.3d 146, 150 (7th Cir. 1994); *Transamerica Ins. Co. v. South*, 975 F.2d 321, 326 (7th Cir. 1992).

[4] The BTA Policy's coverage is further limited to injury "sustained by such person anywhere in the world while on the business of the Policyholder and during the course of any

> "Injury" wherever used in the policy means bodily injury caused by an accident and resulting directly and independently of all other causes in loss covered by the policy,. . . .

(BTA Policy, Section II, Part A; 24-Hour Policy (version PAI 8043756), Part I.)[5] The policies further provide that they do "not cover any loss, fatal or non-fatal, caused by or resulting from . . . disease of any kind. . . . " (BTA Policy, Section IV; 24-Hour Policy (version PAI 8043756), Part III.) Thus, to mount even a credible challenge to the Plan's denial of benefits, Mers' must, at a minimum, satisfy her burden of showing that Dale Mers' death – the claimed loss – (1) was caused by an "accident," (2) resulted directly and independently of all other causes in loss, and (3) was not caused by and did not result from a disease of any kind.

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bonafide trip made by the Insured Person." (BTA Policy, Section II, Part B.)

[5] Mers asserts that the Plan is estopped from relying on the BTA Policy's definition of "injury because that term does not appear in the Summary Plan Description ("SPD"). Yet, the Seventh Circuit has made clear that the language of the SPD controls over the language of the underlying insurance policy "only if there is a contradiction between the summary plan document and the policy." *Senkier v. Hartford Life & Accident Ins. Co.*, 948 F.2d 1050, 1051 (7th Cir. 1991). Here, the language of the BTA Policy's language does not contradict the SPD; rather, it merely clarifies that the loss and accidental loss language in the SPD means "loss resulting from injury." (Ex. H, Pltf. 12(N) Statement, pp. 27-28; BTA Policy, Section III.)

1. Dale Mers' death was caused by an "accident"

Getting a firm handle on the term "accident" as it is used in accidental death and dismemberment insurance policies apparently has been extremely difficult for the courts. In the "old days," courts often distinguished between accidental means – that is, unplanned, unexpected and/or unintended acts or events which cause losses – and accidental results – that is, unanticipated losses resulting from voluntary and/or planned acts – ; injuries caused by accidental means typically were covered, while injuries caused by accidental results generally were not. This means-end distinction eventually was replaced in many courts by a standard of foreseeability – losses that were not reasonably foreseeable by the insured person, whether the products of accidental means or accidental results, were covered as "accidental injuries."

The Seventh Circuit specifically has counseled aginst [sic] rigid adherence to any one of these tests for "accidental injury," however, advising, instead, that the term "accident" be defined by reference to "common understanding":

> Maybe the tests [accidental means, accidental results, foreseeability] are no good. That is what Justice Cardozo thought. He thought courts could do no better than to leave the question to "common understanding as revealed in common speech." *Connelly v. Hunt Furniture Co.*, 240 N.Y. 83, 85, 147 N.E. 366, 367 (1925). We agree. The insured ought to know what he is getting in his insurance policy, so that he can decide whether he would like more coverage at a higher price or less at a lower price. A lay

> person has a clear if inarticulate understanding of the difference between an accidental death and a death from illness, and that understanding will not be altered or improved by head-spinning judicial efforts at definition, such as the mysterious attempt by a court in this state to define disease as that which "originates from a source that is neither traumatic nor physical." *Luttrell v. Industrial Commission*, 154 Ill. App. 3d 943, 955, 107 Ill.Dec. 620, 629, 507 N.E.2d 533, 542 (1987). A person can tell time without being able to define "time" and he can know how to ride a bicycle or shoot pool without being able to explain the principles of physics that enable him to do these things. He can also classify a death as the consequence of illness or accident without being able to define either term.

Senkier, 948 F.2d at 1052-53 (citations omitted).

In *Haley v. American Int'l Life Assurance Co. of New York*, 789 F. Supp. 260 (N.D. Ill. 1992), this Court, in holding that a fatal heart attack, absent a triggering event, could not be considered an accidental injury, attempted to shed some light on the common understanding of the term "accident":

> The word " 'accident' normally designates an unforeseen occurrence, usually of untoward or disastrous character, or an undesigned sudden or unexpected event of an inflictive or unfortunate character. . . . The natural and ordinary consequences of an act do not constitute an 'accident.' " *Farmers Elevator Mutual Life Ins. Co. v. Burch*, 38 Ill.App.2d 249, 252, 187 N.E.2d 12 (4th Dist. 1972);. . . . As a general rule, in the absence of any unexpected or unforeseen trauma, external force or event which causes or

> triggers a heart attack, it is presumed that the death is a death by natural causes, not by an accident.

Haley, 789 F. Supp. at 263 (citations omitted).

In the present case, the parties agree that Dale Mers' death was caused by cardiac arrest due to, or as a consequence of, cerebral hemorrhage; and the medical evidence and expert opinions presented by the parties and relied upon by AIC all suggest that the cerebral hemorrhage resulted from the rupture of a previously weakened blood vessel – an aneurysm – in Dale Mers' brain due to increased vascular pressure caused by his unusual physical exertion at the Habitat for Humanity project. Dale Mers certainly did not expect, and could not have foreseen, that his participation in the project would result in his death – he did not have any knowledge of the existence of any aneurysm – ; and, as opined by Dr. Aven, had Dale Mers not engaged in such strenuous activity at the project, the vascular rupture would not suddenly have happened. A number of courts have found analogous deaths resulting from exertion induced ruptures of pre-existing aneurysms to be "accidents." *See, e.g., Carroll v. CUNA Mutual Ins. Society*, 894 P.2d 746, 753 (Colo. 1995); *Scholle v. Continental Nat'l American Group*, 358 N.E.2d 893, 898-99 (Ill. App. 1976); *Zorn v. Aetna Life Ins. Co.*, 260 F. Supp. 730, 733 (E.D. Tex. 1965). This Court similarly concludes that Dale Mers' death was accidental (as that term is commonly understood), as it was triggered by unusual physical activity and it was not, and, indeed, could not, reasonably have been foreseen or expected. Utilizing an appropriately less deferential arbitrary and capricious standard, the Court thus finds the

Plan's apparent determination that Dale Mers' death was not caused by an accident to be unreasonable.

2. Dale Mers' death did not result directly and independently of all other causes in loss

As previously explained, it is not enough for Mers to show that the Plan was wrong to conclude that Dale Mers' death did not result from an accident; instead, Mers must also show that the Plan abused its discretion in concluding that Dale Mers' death did not result directly and independently of all other causes in loss, including disease.[6] Mers fails to make this necessary showing.

Each and every one of the expert opinions offered by the parties suggests that Dale Mers' cerebral hemorrhage was caused by a ruptured aneurysm – an aneurysm which, by definition, existed prior to, and independent of, Dale Mers' participation in the Habitat for Humanity project on January 5, 1994. Dr. Hier, for example, stated that, "The likely cause of this intracerebral hemorrhage and death is either a sudden rise in blood pressure or a

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[6] Recently, in *Hightshue v. AIG Life Ins. Co.*, 1996 WL 534827, at *9 (S.D. Ind. 1996), the court stated: Clearly, this sentence [resulting directly and independently of all other causes in loss covered by the policy] merely requires that an injury must result "directly" and "independently of all other causes" to be covered by the Plan. In other words, this definition simply limits coverage to bodily injuries resulting directly from an accident and independently of any other case. . . . A person of average intelligence and experience would understand this definition to have the meaning stated. . . .

ruptured arterial aneurysm." (Ex. 1, Def. 12(M) Statement, p. 2.) Dr. Aven opined that, "Since an autopsy was not performed at the time of death, we can only assume from the CT brain scan that the blood within the brain came from an acute hemorrhage, possibly from a ruptured cerebral aneurysm or an arteriosclerotic-weakened vessel." (Ex. 4, Def. 12(M) Statement, p. 2.) Finally, Dr. Harnes stated:

> I cannot agree with the opinion of Dr. Hier that this man's stroke resulted from hypertension due to excessive work. If, as he hypothesizes, the stroke resulted from a subarachnoid hemorrhage secondary to an aneurysm, that bleeding would not be independent of his pre-existing congenital abnormality. Further should the intracerebral hemorrhage be attributed to hypertension, I believe that it would be such an uncommon event in a healthy man of this age that one would have to admit that increased arteriosclerosis resulting from his long standing diabetes played some role in a ruptured cerebral blood vessel.

(Ex. 8, Def. 12(M) Statement.)

The few courts presented with deaths caused by similar physical conditions have held that such deaths cannot be said to have resulted directly and independently of all other causes in loss covered by an accidental death policy. In *Carroll v. CUNA Mutual Insurance Society*, 894 P.2d 746 (Colo. 1995), for example, the court held that a woman's death, which resulted from a massive intracranial hemorrhage caused in turn by the rupture of a preexisting cerebral aneurysm during sexual intercourse with her

husband, was not a covered event under an accidental death insurance policy. The court explained:

> The proper interpretation of the clause "directly and independently of all other causes" is that contained in [*Continental Casualty Co. v. Maguire*, 471 P.2d 636 (Colo. App. 1970)]. Benefits under accidental death or injury policies of the type at issue here are recoverable as long as one can show that the accident is the predominant cause of the loss.
>
> * * *
>
> The evidence even when considered in the light most favorable to Mr. Carroll supports the trial court's findings, which in turn establish that the predominant cause of Mrs. Carroll's death was her preexisting aneurysm and hypertension. Mr. Carroll has not sustained his burden of proving by a preponderance of the evidence that Mrs. Carroll's death was caused "directly and independently of all other causes."

Carroll, 894 P.2d at 754-55, 756.

In *Zorn v. Aetna Life Ins. Co.*, 260 F. Supp. 730 (E.D. Tex. 1965), the court similarly denied benefits to the beneficiary of an accidental death insurance policy whose husband, the insured person, died when his extraordinary physical exertion – he was attempting to handcrank an engine – caused a preexisting cerebral aneurysm to burst. The court stated:

> As indicated by the above quoted provisions of . . . the policy (the exclusionary clause), no insurance is provided and no benefits are payable with respect to any loss if such loss results from an injury which was caused or contributed

> to by or as a consequence of any "bodily infirmity" or "disease of any kind," even though the proximate or precipitating cause of said loss was a bodily injury caused by an accident.
>
> * * *
>
> An abnormal weakness in the wall of a blood vessel plainly falls within such definition. Thus, the Court finds and concludes that the preexisting aneurysm in the blood vessel in Zorn's brain constituted a "bodily infirmity' [sic] within the meaning of the exclusionary clause of the insurance policy, and since Zorn's injury was contributed to by said aneurysm, Aetna is not liable for the payment of the death benefits provided for in the policy in question.

Zorn, 260 F. Supp. at 733.

Finally, the court in *Sugarman v. New England Mutual Life Ins. Co.*, 201 F. Supp. 759 (E.D.N.Y. 1962), concluded that an insured's death caused by the rupture of an undetected, congenital aneurysm when the insured struck his head on a staircase was not covered by an accidental death insurance policy containing a disease exclusion substantially similar to the one in both the BTA Policy and the 24-Hour Policy. The *Sugarman* court wrote:

> None of the cases authorizes a conclusion that death from the rupture of such an aneurysm as the insured unknowingly harbored can be found as a fact to be death due to injury effected solely through accidental means and not resulting wholly or partly, directly or indirectly from any disease or infirmity. As a matter of law the morbidity of the artery bearing the aneurysm the rupture of which caused death was a grave infirmity or disease; its role in producing death

> precludes recovery even if an accidental blow or fall produced the increase in intracranial pressure that effected the fatal rupture of the aneurysm.

Sugarman, 201 F. Supp. at 762; *see also Criss v. Hartford Accident & Indem. Co.*, 1992 WL 113370, *2-4, *6 (6th Cir. 1992); *McFarlane v. Life Ins. Co.*, 999 F.2d 266, 267 (7th Cir. 1993).

Thus, as with the deceased insureds in *Carroll*, *Zorn*, and *Sugarman*, it cannot be said that Dale Mers' death resulted directly and independently of all other causes in loss and/or that his death was not caused by and did not result from a disease of any kind. At the very least, even under a less deferential arbitrary and capricious standard of review that accounts for AIC's inherent conflict of interest, this Court concludes, as a matter of law, that the Plan's determinations (1) that Dale Mers' death was caused, in large part, by a preexisting condition, infirmity or disease (i.e. either an aneurysm or an arteriosclerotic-weakened blood vessel) and (2) that, consequently, his death was not covered by the 24-Hour or the BTA Policies were entirely reasonable and appropriate in light of the available medical evidence, the largely undisputed facts, and the relevant judicial precedent.[7] Accordingly,

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[7] Although Mers repeatedly argues that because the BTA Policy is ambiguous as to the precise scope of its coverage, the Policy should be construed strictly in favor of coverage and against the Plan – a concept typically referred to as the doctrine of *contra proferentem* – , this argument has been explicitly rejected by the Seventh Circuit where, as here, discretion is

summary judgment should be granted in favor of the Plan and against Mers.

CONCLUSION

For the foregoing reasons, the Court grants the Plan's motion for summary judgment and denies Mers' motion for summary judgment.

ENTER:

GEORGE M. MAROVICH
UNITED STATES DISTRICT JUDGE

DATED:

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granted to plan administrators and/or fiduciaries to interpret the plan's terms:

> The federal common law of ERISA does provide that ambiguous terms in benefit plans should be construed in favor of beneficiaries. But this rule has no application here. Often called the rule of contra proferentem, it is a device for determining the intended meaning of a contract term in the absence of conclusive evidence about intent. Courts invoke this rule when they have the authority to construe the terms of a plan, but this authority arises only when the administrators of the plan lack the discretion to construe it themselves. . . . When the administrators of a plan have discretionary authority to construe the plan, they have the discretion to determine the intended meaning of the plan's terms. In making a deferential review of such determinations, courts have no occasion to employ the rule of contra proferentem.

Morton v. Smith, 91 F.3d 867, 871 n.1 (7th Cir. 1996).

29 USC § 1022. Plan description and summary plan description

(a)(1) A summary plan description of any employee benefit plan shall be furnished to participant and beneficiaries as provided in section 1024(b) of this title. The summary plan description shall include the information described in subsection (b) of this section, shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan. A summary of any material modification in the terms of the plan and any change in the information required under subsection (b) of this section shall be written in a manner calculated to be understood by the average plan participant and shall be furnished in accordance with section 1024(b)(1) of this title.

(2) A plan description (containing the information required by subsection (b) of this section) of any employee benefit plan shall be prepared on forms prescribed by the Secretary, and shall be filed with the Secretary as required by section 1024(a)(1) of this title. Any material modification in the terms of the plan and any change in the information described in subsection (b) of this section shall be filed in accordance with section 1024(a)(1)(D) of this title.

(b) The plan description and summary plan description shall contain the following information. The name and type of administration of the plan; the name and address of the

person designated as agent for the service of legal process, if such person is not the administrator; the name and address of the administrator; names, titles and addresses of any trustee or trustees (if they are persons different from the administrator); a description of the relevant provisions of any applicable collective bargaining agreement; the plan's requirements respecting eligibility for participation and benefits; a description of the provisions providing for nonforfeitable pension benefits; circumstances which may result in disqualification, ineligibility, or denial or loss of benefits, the source of financing of the plan and the identity of any organization through which benefits are provided; the date of the end of the plan year and whether the records of the plan are kept on a calendar, policy, or fiscal year basis; the procedures to be followed in presenting claims for benefits under the plan and the remedies available under the plan for the redress of claims which are denied in whole or in part (including procedures required under section 1133 of this title).

29 USC § 1104. Fiduciary duties

(a) Prudent man standard of care

(1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and –

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

(C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter and subchapter III of this chapter.

(2) In the case of an eligible individual account plan (as defined in section 1107(d)(3) of this title), the diversification requirement of paragraph (1)(C) and the prudence requirement (only to the extent that it requires diversification) of paragraph (1)(B) is not violated by acquisition or holding of qualifying employer real property or

qualifying employer securities (as defined in section 1107(d)(4) and (5) of this title).

(b) Indicia of ownership of assets outside jurisdiction of district courts

Except as authorized by the Secretary by regulation, no fiduciary may maintain the indicia of ownership of any assets of a plan outside the jurisdiction of the district courts of the United States.

(c) Control over assets by participant or beneficiary

In the case of a pension plan which provides for individual accounts and permits a participant or beneficiary to exercise control over the assets in his account, if a participant or beneficiary exercises control over the assets in his account (as determined under regulations of the Secretary) –

(1) such participant or beneficiary shall not be deemed to be a fiduciary by reason of such exercise, and

(2) no person who is otherwise a fiduciary shall be liable under this part for any loss, or by reason of any breach, which results from such participant's or beneficiary's exercise of control.

(d) Plan terminations

(1) If, in connection with the termination of a pension plan which is a single-employer plan, there is an election to establish or maintain a qualified replacement plan, or to increase benefits as provided under section 4980(d) of Title 26, a fiduciary shall discharge the fiduciary's duties under

this subchapter and subchapter III of this chapter in accordance with the following requirements:

(A) In the case of a fiduciary of the terminated plan, any requirement –

(i) under section 4980(d)(2)(B) of Title 26 with respect to the transfer of assets from the terminated plan to a qualified replacement plan, and

(ii) under section 4980(d)(2)(B)(ii) or 4980(d)(3) of Title 26 with respect to any increase in benefits under the terminated plan.

(B) In the case of a fiduciary of a qualified replacement plan, any requirement –

(i) under section 4980(d)(2)(A) of Title 26 with respect to participation in the qualified replacement plan of active participants in the terminated plan,

(ii) under section 4980(d)(2)(B) of Title 26 with respect to the receipt of assets from the terminated plan, and

(iii) under section 4980(d)(2)(C) of Title 26 with respect to the allocation of assets to participants of the qualified replacement plan.

(2) For purposes of this subsection –

(A) any term used in this subsection which is also used in section 4980(d) of Title 26 shall have the same meaning as when used in such section, and

(B) any reference in this subsection to Title 26 shall be a reference to Title 26 as in effect

immediately after the enactment of the Omnibus Budget Reconciliation Act of 1990.

29 USC § 1132. Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought –

(1) by a participant or beneficiary –

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

(6) by the Secretary to collect any civil penalty under subsection (c)(2) or (i) or (l) of this section;

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 1169(a)(2)(A) of this title);

(8) by the Secretary, or by an employer or other person referred to in section 1021(f)(1) of this title, (A) to enjoin any act or practice which violates subsection (f) of section 1021 of this title, or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection; or

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this subtitle or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts.

(b) Plans qualified under Internal Revenue Code; maintenance of actions involving delinquent contributions

(1) In the case of a plan which is qualified under section 401(a), 403(a), or 405(a) of Title 26 (or

with respect to which an application to so qualify has been filed and has not been finally determined) the Secretary may exercise his authority under subsection (a)(5) of this section with respect to a violation of, or the enforcement of, parts 2 and 3 of this subtitle (relating to participation, vesting, and funding), only if –

(A) requested by the Secretary of the Treasury, or

(B) one or more participants, beneficiaries, or fiduciaries, of such plan request in writing (in such manner as the Secretary shall prescribe by regulation) that he exercise such authority on their behalf. In the case of such a request under this paragraph he may exercise such authority only if he determines that such violation affects, or such enforcement is necessary to protect, claims of participants or beneficiaries to benefits under the Plan.

(2) The Secretary shall not initiate an action to enforce section 1145 of this title.

(c) **Refusal to supply requested information; failure to comply with notice requirements; penalties**

(1) Any administrator (A) who fails to meet the requirements of paragraph (1) or (4) of section 1166 of this title or section 1021(e)(1) of this title with respect to a participant or beneficiary, or (B) who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of

the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper.

(2) The Secretary may assess a civil penalty against any plan administrator of up to $1,000 a day from the date of such plan administrator's failure or refusal to file the annual report required to be filed with the Secretary under section 1021(b)(4) of this title. For purposes of this paragraph, an annual report that has been rejected under section 1024(a)(4) of this title for failure to provide material information shall not be treated as having been filed with the Secretary.

(3) Any employer maintaining a plan who fails to meet the notice requirement of section 1021(d) of this title with respect to any participant or beneficiary or who fails to meet the requirements of section 1021(e)(2) of this title with respect to any person may in the court's discretion be liable to such participant or beneficiary or to such person in the amount of up to $100 a day from the date of such failure, and the court may in its discretion order such other relief as it deems proper.

(4) The Secretary may assess a civil penalty of not more than $1,000 for each violation by any person of section 1021(f)(1) of this title. For purposes of this paragraph, each violation described in subparagraph (A) with respect to any single participant, and each violation described in subparagraph (B) with respect to any single participant or beneficiary, shall be treated as a separate violation. The Secretary and the Secretary of

Health and Human Services shall maintain such ongoing consultation as may be necessary and appropriate to coordinate enforcement under this subsection with enforcement under section 1320b-14(c)(8) of Title 42.

(d) Status of employee benefit plan as entity

(1) An employee benefit plan may sue or be sued under this subchapter as an entity. Service of summons, subpoena, or other legal process of a court upon a trustee or an administrator of an employee benefit plan in his capacity as such shall constitute service upon the employee benefit plan. In a case where a plan has not designated in the summary plan description of the plan an individual as agent for the service of legal process, service upon the Secretary shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the administrator or any trustee of the plan of receipt of such service.

(2) Any money judgment under this subchapter against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this subchapter.

(e) Jurisdiction

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section

1021(f)(1) of this title. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

(2) Where an action under this subchapter is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

(f) Amount in controversy; citizenship of parties

The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

(g) Attorney's fees and costs; awards in actions involving delinquent contributions

(1) In any action under this subchapter (other than an action described in paragraph (2)) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

(2) In any action under this subchapter by a fiduciary for or on behalf of a plan to enforce section 1145 of this title in which a judgment in favor of the plan is awarded, the court shall award the plan –

(A) the unpaid contributions,

(B) interest on the unpaid contributions,

(C) an amount equal to the greater of –

(i) interest on the unpaid contributions, or

(ii) liquidated damages provided for under the plan in an amount not in excess of 20 percent (or such higher percentage as may be permitted under Federal or State law) of the amount determined by the court under subparagraph (A),

(D) reasonable attorney's fees and costs of the action, to be paid by the defendant, and

(E) such other legal or equitable relief as the court deems appropriate.

For purposes of this paragraph, interest on unpaid contributions shall be determined by using the rate provided under the plan, or, if none, the rate prescribed under section 6621 of Title 26.

(h) Service upon Secretary of Labor and Secretary of Treasury

A copy of the complaint in any action under this subchapter by a participant, beneficiary, or fiduciary (other than an action brought by one or more participants or beneficiaries under subsection (a)(1)(B) of this section which is solely for the purpose of recovering benefits due such participants under the terms of the plan) shall be served upon the Secretary and the Secretary of the Treasury by certified mail. Either Secretary shall have the right in his discretion to intervene in any action, except that the Secretary of the Treasury may not intervene in any action under part 4 of this subtitle. If the Secretary brings an action under subsection (a) of this section on behalf of

a participant or beneficiary, he shall notify the Secretary of the Treasury.

(i) Administrative assessment of civil penalty

In the case of a transaction prohibited by section 1106 of this title by a party in interest with respect to a plan to which this part applies, the Secretary may assess a civil penalty against such party in interest. The amount of such penalty may not exceed 5 percent of the amount involved in each such transaction (as defined in section 4975(f)(4) of Title 26) for each year or part thereof during which the prohibited transaction continues, except that, if the transaction is not corrected (in such manner as the Secretary shall prescribe in regulations which shall be consistent with section 4975(f)(5) of Title 26) within 90 days after notice from the Secretary (or such longer period as the Secretary may permit), such penalty may be in an amount not more than 100 percent of the amount involved. This subsection shall not apply to a transaction with respect to a plan described in section 4975(e)(1) of Title 26.

(j) Direction and control of litigation by Attorney General

In all civil actions under this subchapter, attorneys appointed by the Secretary may represent the Secretary (except as provided in section 518(a) of Title 28), but all such litigation shall be subject to the direction and control of the Attorney General.

(k) Jurisdiction of actions against the Secretary of Labor

Suits by an administrator, fiduciary, participant, or beneficiary of an employee benefit plan to review a final order of the Secretary, to restrain the Secretary from taking any action contrary to the provisions of this chapter, or to compel him to take action required under this subchapter, may be brought in the district court of the United States for the district where the plan has its principal office, or in the United States District Court for the District of Columbia.

(l) Civil penalties on violations by fiduciaries

(1) In the case of –

(A) any breach of fiduciary responsibility under (or other violation of) part 4 by a fiduciary, or

(B) any knowing participation in such a breach or violation by any other person,

the Secretary shall assess a civil penalty against such fiduciary or other person in an amount equal to 20 percent of the applicable recovery amount.

(2) For purposes of paragraph (1), the term "applicable recovery amount" means any amount which is recovered from a fiduciary or other person with respect to a breach or violation described in paragraph (1) –

(A) pursuant to any settlement agreement with the Secretary, or

(B) ordered by a court to be paid by such fiduciary or other person to a plan or its participants and beneficiaries in a judicial

proceeding instituted by the Secretary under subsection (a)(2) or (a)(5) of this section.

(3) The Secretary may, in the Secretary's sole discretion, waive or reduce the penalty under paragraph (1) if the Secretary determines in writing that –

(A) the fiduciary or other person acted reasonably and in good faith, or

(B) it is reasonable to expect that the fiduciary or other person will not be able to restore all losses to the plan (or to provide the relief ordered pursuant to subsection (a)(9) of this section) without severe financial hardship unless such waiver or reduction is granted.

(4) The penalty imposed on a fiduciary or other person under this subsection with respect to any transaction shall be reduced by the amount of any penalty or tax imposed on such fiduciary or other person with respect to such transaction under subsection (i) of this section and section 4975 of Title 26.

(m) Penalty for improper distribution

In the case of a distribution to a pension plan participant or beneficiary in violation of section 1056(e) of this title by a plan fiduciary, the Secretary shall assess a penalty against such fiduciary in an amount equal to the value of the distribution. Such penalty shall not exceed $10,000 for each such distribution.

CODE OF FEDERAL REGULATIONS TITLE 29 – LABOR SUBTITLE B – REGULATIONS RELATING TO LABOR CHAPTER XXV – PENSION AND WELFARE BENEFITS ADMINISTRATION, DEPARTMENT OF LABOR SUBCHAPTER C – REPORTING AND DISCLOSURE UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 PART 2520 – RULES AND REGULATIONS FOR REPORTING AND DISCLOSURE SUBPART B – CONTENTS OF PLAN DESCRIPTIONS AND SUMMARY PLAN DESCRIPTIONS

§ 2520.102-2 Style and format of summary plan description.

(a) Method of presentation. The summary plan description shall be written in a manner calculated to be understood by the average plan participant and shall be sufficiently comprehensive to apprise the plan's participants and beneficiaries of their rights and obligations under the plan. In fulfilling these requirements, the plan administrator shall exercise considered judgment and discretion by taking into account such factors as the level of comprehension and education of typical participants in the plan and the complexity of the terms of the plan. Consideration of these factors will usually require the limitation or elimination of technical jargon and of long, complex sentences, the use of clarifying examples and illustrations, the use of clear cross references and a table of contents.

(b) General format. The format of the summary plan description must not have the effect to [sic] misleading, misinforming or failing to inform participants and beneficiaries. Any description of exception, limitations, reductions, and other restrictions of plan benefits shall not be

minimized, rendered obscure or otherwise made to appear unimportant. Such exceptions, limitations, reductions, or restrictions of plan benefits shall be described or summarized in a manner not less prominent than the style, captions, printing type, and prominence used to describe or summarize plan benefits. The advantages and disadvantages of the plan shall be presented without either exaggerating the benefits or minimizing the limitations. The description or summary of restrictive plan provisions need not be disclosed in the summary plan description in close conjunction with the description or summary of benefits, provided that adjacent to the benefit description the page on which the restrictions are described is noted.

(c) Foreign languages. In the case of either –

(1) A plan that covers fewer than 100 participants at the beginning of a plan year, and in which 25 percent or more of all plan participants are literate only in the same non-English language, or

(2) A plan which covers 100 or more participants at the beginning of the plan year, and in which the lesser of (i) 500 or more participants, or (ii) 10% or more of all plan participants are literate only in the same non-English language, so that a summary plan description in English would fail to inform these participants adequately of their rights and obligations under the plan, the plan administrator for such plan shall provide these participants with an English-language summary plan description which prominently displays a notice, in the non-English language common to these participants, offering them assistance. The assistance provided need not

involve written materials, but shall be given in the non-English language common to these participants and shall be calculated to provide them with a reasonable opportunity to become informed as to their rights and obligations under the plan. The notice offering assistance contained in the summary plan description shall clearly set forth in the non-English language common to such participants offering them assistance. The assistance provided need not involve written materials, but shall be given in the non-English language common to these participants and shall be calculated to provide them with a reasonable opportunity to become informed as to their rights and obligations under the plan. The notice offering assistance contained in the summary plan description shall clearly set forth in the non-English language common to such participants the procedures they must follow in order to obtain such assistance.

Example. Employer A maintains a pension plan which covers 1000 participants. At the beginning of a plan year five hundred of Employer A's covered employees are literate only in Spanish, 101 are literate only in Vietnamese, and the remaining 399 are literate in English. Each of the 1000 employees receives a summary plan description in English, containing an assistance notice in both Spanish and Vietnamese stating the following:

"This booklet contains a summary in English of your plan rights and benefits under Employer A Pension Plan. If you have difficulty understanding any part of this booklet, contact Mr. John Doe, the plan administrator, at his office in Room 123, 456 Main St., Anywhere City, State

20001. Office hours are from 8:30 A.M. to 5:00 P.M. Monday through Friday. You may also call the plan administrator's office at (202) 555-2345 for assistance."

[42 FR 37180, July 19, 1977]

CODE OF FEDERAL REGULATIONS TITLE 29 – LABOR SUBTITLE B – REGULATIONS RELATING TO LABOR CHAPTER XXV – PENSION AND WELFARE BENEFITS ADMINISTRATION, DEPARTMENT OF LABOR SUBCHAPTER C – REPORTING AND DISCLOSURE UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 PART 2520 – RULES AND REGULATIONS FOR REPORTING AND DISCLOSURE SUBPART B – CONTENTS OF PLAN DESCRIPTIONS AND SUMMARY PLAN DESCRIPTIONS

§ 2520.102-3 Contents of summary plan description.

Section 102 of the Act specifies information that must be included in the summary plan description. The summary plan description must accurately reflect the contents of the plans as of the date not earlier than 120 days prior to the date such summary plan description is disclosed. The following information shall be included in the summary plan description of both employee welfare benefit plans and employee pension benefit plans, except as stated otherwise in paragraph (j) through (n):

(a) The name of the plan, and, if different, the name by which the plan is commonly known by its participants and beneficiaries;

(b) The name and address of –

(1) In the case of a single employer plan, the employer whose employees are covered by the plan,

(2) In the case of a plan maintained by an employee organization for its members, the employee organization that maintains the plan,

(3) In the case of a collectively-bargained plan established or maintained by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, parent or most significantly employer of a group of employers all of which contribute to the same plan, or other similar representative of the parties who established or maintain the plan, as well as

(i) A statement that a complete list of the employers and employee organizations sponsoring the plan may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and beneficiaries, as required by §§ 2520.104b-1 and 2520.104b-30; or

(ii) A statement that participants and beneficiaries may receive from the plan administrator, upon written request, information as to whether a particular employer or employee organization is a sponsor of the plan and, if the employer or employee organization is a plan sponsor, the sponsor's address.

(4) In the case of a plan established or maintained by two or more employers, the association, committee, joint board of trustees, parent or most significant employer of a group of employers all of which contribute to the same plan, or other similar representative of the parties who established or maintain the plan, as well as

(i) A statement that a complete list of the employers sponsoring the plan may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and

beneficiaries, as required by §§ 2520.104b-1 and 2520.104b-30, or,

(ii) A statement that participants and beneficiaries may receive from the plan administrator, upon written request, information as to whether a particular employer is a sponsor of the plan and, if the employer is a plan sponsor, the sponsor's address.

(c) the employer identification number (EIN) assigned by the Internal Revenue Service to the plan sponsor and the plan number assigned by the plan sponsor. (For further detailed explanation, see the instructions to the plan description Form EBS-1 and "Identification Numbers Under ERISA" (Publ. 1004), published jointly by DOL, IRS, and PBGC);

(d) The type of pension or welfare plan, e.g., for pension plans – defined benefit, money purchase, profit sharing, etc., and for welfare plans – hospitalization, disability, pre-paid legal service, etc.;

(e) The type of administration of the plan, e.g., control administration, insurer administration, etc.;

(f) The name, business address and business telephone number of the plan administrator as that term is defined by section 3(16) of the Act;

(g) The name of the person designated as agent for service of legal process, and the address at which process may be served on such person, and in addition, a statement that service of legal process may be made upon a plan trustee or the plan administrator;

(h) The name, title and address of the principal place of business of each trustee of the plan;

(i) If a plan is maintained pursuant to one or more collective bargaining agreements, a statement that the plan is so maintained, and that a copy of any such agreement may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and beneficiaries, as required by §§ 2520.104b-1 and 2520.104b-30. For the purpose of this paragraph, a plan is maintained pursuant to a collective bargaining agreement if such agreement controls any duties, rights or benefits under the plan, even though such agreement has been superseded in part for other purposes;

(j) The plan's requirements respecting eligibility for participation and for benefits. The summary plan description shall describe the plan's provisions relating to eligibility to participate in the plan, such as age or years of service requirements, and the items listed in paragraphs (j)(1) or (2) of this section as appropriate:

(1) For employee pension benefit plans, it shall also include a statement describing the plan's normal retirement age, as that term is defined in section 3(24) of the Act, and a statement describing any other conditions which must be met before a participant will be eligible to receive benefits. Such plan benefits shall be described or summarized.

(2) For employee welfare benefit plans, it shall also include a statement of the conditions pertaining to eligibility to receive benefits, and a description or summary of the benefits. In the case of a welfare plan providing extensive schedules of benefits (a medical care plan, for

example), only a general description is required if reference is made to detailed schedules of benefits which are available without cost to any participant or beneficiary who so requests;

(k) In the case of an employee pension benefit plan, a statement describing any joint and survivor benefits provided under the plan, including any requirement that an election be made as a condition to select or reject the joint and survivor annuity;

(l) For both pension and welfare benefit plans, a statement clearly identifying circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture or suspension of any benefits that a participant or beneficiary might otherwise reasonably expect the plan to provide on the basis of the description of benefits required by paragraphs (j) and (k) of this section.

(m) For an employee pension benefit plan the following information:

(1) If the benefits of the plan are not insured under Title IV of the Act, a statement of this fact, and reason for the lack of insurance; and

(2) If the benefits of the plan are insured under Title IV of the Act, a statement of this fact, a summary of the pension benefit guaranty provisions of Title IV, and a statement indicating that further information on the provisions of Title IV can be obtained from the plan administrator or the Pension Benefit Guaranty Corporation. The address of the PBGC shall be provided.

(3) A summary plan description will be deemed to have complied with paragraph (m)(2) of this section if it

includes the following statement in the summary plan description.

Benefits under this plan are insured by the Pension Benefit Guaranty Corporation (PBGC) if the plan terminates. Generally, the PBGC guarantees most vested normal age retirement benefits, early retirement benefits, and certain disability and survivor's pensions. However, PBGC does not guarantee all types of benefits under covered plans, and the amount of benefit protection is subject to certain limitations.

The PBGC guarantees vested benefits at the level in effect on the date of plan termination. However, if a plan has been in effect less than five years before it terminates, or if benefits have been increased within the five years before plan termination, the whole amount of the plan's vested benefits or the benefit increase may not be guaranteed. In addition, there is a ceiling on the amount of monthly benefit that PBGC guarantees, which is adjusted periodically.

For more information on the PBGC insurance protection and its limitations, ask your Plan Administrator or the PBGC. Inquiries to the PBGC should be addressed to the Office of Communications, PBGC, 2020 K Street N [sic] W., Washington, D.C. 20006. The PBGC Office of Communications may also be reached by calling (202) 254-4817.

(n) In the case of an employee pension benefit plan, a description and explanation of the plan provisions for determining years of service for eligibility to participate, vesting, and breaks in service, and years of participation for benefit accrual. The description shall state the service

required to accrue full benefits and the manner in which accrual of benefits is prorated for employees failing to complete full service for a year.

(o) In the case of an employee pension benefit plan that will use the "cutback" rule of Internal Revenue Service Revenue Ruling 76-378, IRB 1976-40, October 4, 1976, to make retroactive changes in the vesting or accrual provisions described in the summary plan description, a statement that certain provisions of the plan are subject to amendment which directly or indirectly modifies certain plan rights and benefits, the nature of such modifications, the identification by reference of such plan provisons, and the identification by reference of the portions of the summary plan description where such provisions are described. Such statement may be either printed within the text of the summary plan description or it may be printed in a separate sheet and disclosed together with the summary plan description.

(p) The sources of contributions to the plan – for example, employer, employee organization, employees – and the method by which the amount of contribution is calculated. Defined benefit pension plans may state without further explanation that the contribution is actuarially determined.

(q) The identity of any funding medium used for the accumulation of assets through which benefits are provided. The summary plan description shall identify any insurance company, trust fund, or any other institution, organization, or entity which maintains a fund on behalf of the plan or through which the plan is funded or benefits are provided. If a health insurance issuer, within

the meaning of section 733(b)(2) of the Act, is responsible, in whole or in part, for the financing or administration of a group health plan, the summary plan description shall indicate the name and address of the issuer, whether and to what extent benefits under the plan are guaranteed under a contract or policy of insurance issued by the issuer, and the nature of any administrative services (e.g., payment of claims) provided by the issuer.

(r) The date of the end of the year for purposes of maintaining the plan's fiscal records;

(s) The procedures to be followed in presenting claims for benefits under the plan and the remedies available under the plan for the redress of claims which are denied in whole or in part (including procedures required under section 503 of Title I of the Act); and

(t)(1) The statement of ERISA rights described in section 104(c) of the Act, containing the items of information applicable to the plan included in the model statement of paragraph (t)(2) of this section. Items which are not applicable to the plan are not required to be included. The statement may contain explanatory and descriptive provisions in addition to those prescribed in paragraph (t)(2) of this section. However, the style and format of the statement shall not have the effect of misleading, misinforming or failing to inform participants and beneficiaries of a plan. All such information shall be written in a manner calculated to be understood by the average plan participant, taking into account factors such as the level of comprehension and education of typical participants in the plan and the complexity of the items required under

this subparagraph to be included in the statement. Inaccurate, incomprehensible or misleading explanatory material will fail to meet the requirements of this section. The statement of ERISA rights (the model statement or a statement prepared by the plan), must appear as one consolidated statement. If a plan finds it desirable to make additional mention of certain rights elsewhere in the summary plan description, it may do so. The summary plan description may state that the statement of ERISA rights is required by federal law and regulation.

(2) A summary plan description will be deemed to comply with the requirements of paragraph (e)(1) of the section if it includes the following statement; items of information which are not applicable to a particular plan may be deleted: As a participant in (name of plan) you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.

Obtain copies of all plan documents and other plan information upon written request to the plan administrator. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age***) and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once a year. The plan must provide the statement free of charge.

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA. If your claim for a (pension, welfare) benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you

up to $100 a day until you receive the material's, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, it finds your claim if [sic] frivolous. If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

(u) In the case of a group health plan, as defined in section 733(a)(1) of the Act, that provides maternity or newborn infant coverage, a statement indicating that group health plans and health insurance issuers offering group insurance coverage generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarean

section, or require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

(v) Applicability dates.

(1) The information described in the last sentence of paragraph (q) and in the last sentence of paragraph (t)(2) shall be treated as a change in the information required to be included in the summary plan description for a group health plan for purposes of 29 CFR 2520.104b-3, except that such information shall be furnished to each participant covered under the plan and each beneficiary receiving benefits under the plan not later than 60 days after the first day of the first plan year beginning after June 30, 1997.

(2) The information described in paragraph (u) of this section shall be furnished to each participant covered under a group health plan and each beneficiary receiving benefits under a group health plan not later than 60 days after the first day of the first plan year beginning on or after January 1, 1998.

(Approved by the Office of Management and Budget under control number 1210-0039.)

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